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PLAN OF THE INDEX

This index to Volume XXXIV of The Journal, that of the year 1937, is made up according to the departments of The Journal, as follows:

1. Original Articles (scientific)
2. Authors of Original Articles
3. Editorials
4. State Society Activities
5. County Society Activities and Reports
6. Woman's Auxiliary
7. Obituaries
8. Book Reviews

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The Official List of Fellows, Officers, Delegates, and Members was published as a supplement to The Journal of April, 1937.

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The officers and committeemen of the State Society are listed in the advertising section of each Journal,—pages III-VI, immediately following the front cover.

ANNUAL MEETING MINUTES

The minutes of the Annual Meeting and the House of Delegates are contained in the OFFICIAL TRANSACTIONS, which was issued as a supplement to the July, 1937, issue, with its own index on the first page.

ANNUAL REPORTS

The annual reports of the Officers and Committees were printed in The Journal of April, 1937, pages 225-283, with its own index on page 283.

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Annual Meeting April 27-29, 1937, in Atlantic City, N. J.

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N. Y. State Jour. Med. 1935, 35—No. 11, 590; Laryngoscope 1935 XLV, 149-154. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245. ☐

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*Dr. Russell Cecil, N. Y. S. Jour. of Medicine, Vol. 35, Nov. 15, 1935, No. 22, p. 7.



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I. MINERALS

● Considerable differences may exist between the mineral contents of foods from both the qualitative and quantitative standpoints. In fact, variation in mineral content has been noted even in the same plant variety; such variations being dependent, among other factors, upon soil or climatic conditions (1).

A striking example of the influence of one of these factors is the relative richness in iodine of field crops raised in certain coastal regions of this country where the soil is also high in iodine.

From the point of view of those concerned with human nutrition, interest in the mineral content of the food supply is usually centered around calcium, iron and iodine; since it is generally agreed that of all the essential minerals, these are the ones most apt to be inadequately supplied by the average varied diet. Conservation of these minerals in foods is, therefore, a matter of considerable practical interest.

Unlike the vitamins, minerals are not lost during storage of fruits and vegetables. However, solution losses during cooking may be severe, due to the fact that most minerals, as they occur in the plant, are soluble, or at least are extractable, by the water in which they are cooked. For example, cabbage cooked by the usual home method has been shown to lose from 21 to 72 per cent of its calcium (2).

As exemplified by these studies, solution losses of minerals in leafy vegetables are usually high. Losses in vegetables as a class are not, however, so excessive, as indicated by an average reported loss of 19.5 per cent of the calcium in seven common vegetables (3).

The average decrease during cooking in the ash content of five common vegetables has been found to approximate 37 per cent (4).

While the extent of mineral loss during ordinary home cooking methods will vary with the particular element under consideration as well as the food in which it is contained, sufficient evidence is at hand to indicate that such losses may be considerable. It is further apparent that discarding the cooking water—the usual home practice—entails a loss of valuable, essential mineral components of food.

Modern practice in commercial canning goes far in preventing these solution losses of minerals. Canned foods are cooked by the heat process accorded them while still contained within the hermetically sealed can. A minimum of water is used which also remains within the can, conserving for the consumer's use those extractable essential mineral elements which may be lost to the cooking water during home preparation of market varieties of foods.

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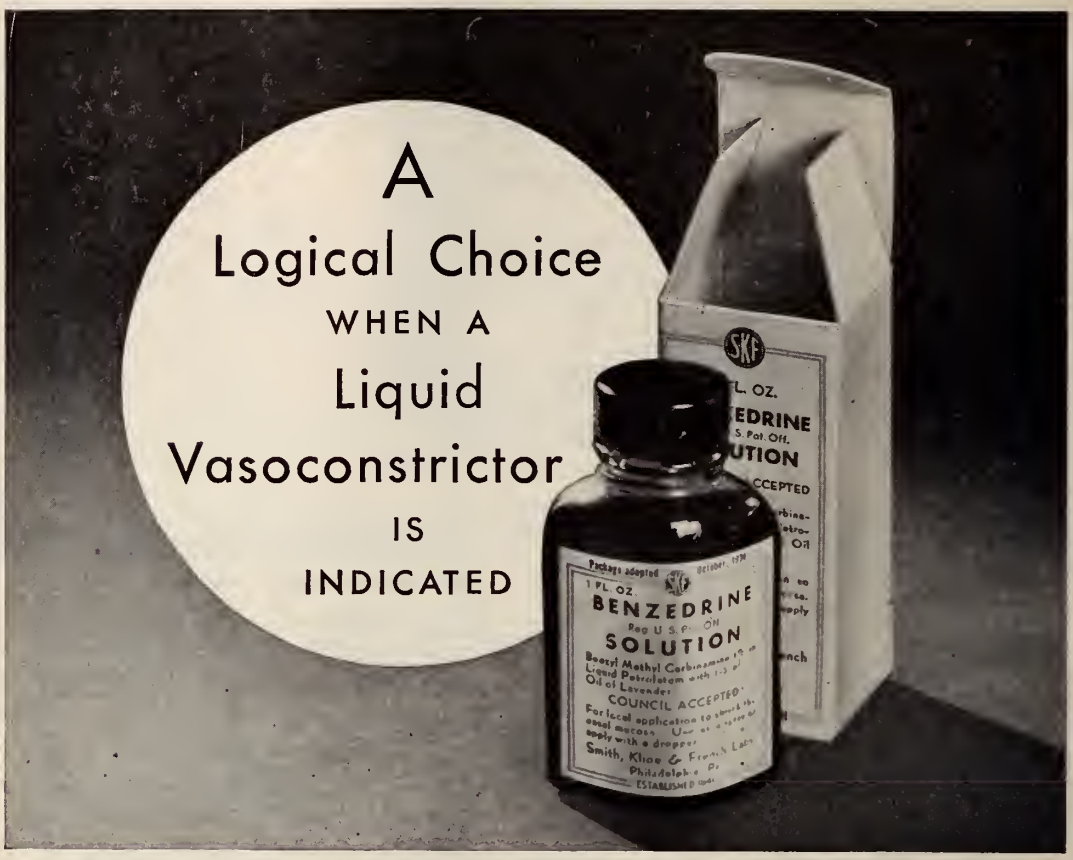
230 Park Avenue, New York City

(1) 1936 J. Nutrition 11, 55.
(2) 1936 J. Home Econ. 28, 18. 1925 Ibid, 17, 265
(3) 1935 J. Home Econ. 27, 376
(4) 1917 Amer. J. Dis. Chila, 14, 34

This is the twentieth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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Giordano: Penna. Med. Jour.: Oct., 1935

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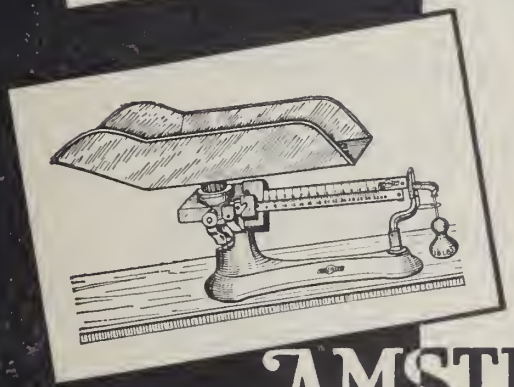
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Volume XXXIV.
Number 1

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly

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Executive Officer—LeRoy A. Wilkes, M.D.
Each member of the State Society is entitled to receive a copy of The Journal every month.

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EDITORIALS

The Small County Society

Each county society is a replica of The Medical Society of New Jersey. Each of the five county societies which have only twenty-five members has the same kind of problems as the five whose members number two hundred or more. As a matter of fact, each member in the smaller group of societies is responsible for medical service to as large a number of people as a member of the large societies; and he has the great advantage of an intimate acquaintance with *all* the civic leaders in his county.

The Medical Society of New Jersey recognizes the autonomy of each county society by its requirement that each county society shall have a representative on its two most vital committees,—the Welfare and the Nominating.

The influence which a member exerts depends upon himself, and his reaction to the universal principles of civic duty. The opportunity of a member to render honorable service in the smallest society is even greater than that which comes to a member of a great society where competition is keen.

The history of the many smaller county societies goes back to the earlier days when they were the largest in the State in size and influence. Hunterdon was the most populous county in 1766 when the Medical Society was organized, and Middlesex was the most influential. The rural societies are now larger and exert a greater influence than ever before. They seem small only because commercial conditions unsuspected in earlier days have brought a concentration of population in great cities. Yet the people of the smaller counties receive medical service of a grade as high as that which is delivered in the cities. The only kind of service in which the great cities excel the rural communities is that of the large hospitals and of the specialists whose services are available everywhere in the State. It seems to be a fact that the specialist envies the rural practitioner more than the rural practitioner does the city doctor.

An apprehension of these facts will lead the members of the smaller county societies to exercise the influence which is rightfully theirs. Some day a list will be made of the counties which have supplied the Presidents of the State Society.

Then and Now in Recent Medical History

Where two or three doctors are gathered together, there is a discussion of "State Medicine".

History is repeating itself every day, and will continue to do so until time shall end; but the disputes of the present day are mild compared with the open warfare which existed a half century ago.

Some of us have a vivid recollection of the intense opposition of medical men to the participation of Departments of Health in providing diphtheria antitoxin, and insisting on its use. The doses at first were entirely too small—3000 units as a maximum. Allergic reactions occurred frequently because of the large amounts of unrefined horse serum that were required; and there was some justification of the fear that the antitoxin itself might produce evident symptoms which were worse than those of a mild attack of diphtheria.

Up to the end of the decade of the nineties many of the older doctors asserted their disbelief in the germ theory of contagious diseases, and the lot of the young graduate in medicine was unenviable. But the curative results of antitoxin were often so spectacular that people demanded it and forced the reactionary physicians to adopt its use.

In those days nothing was said about "State Medicine", but much was said against "contract practice", especially "lodge practice". Many a young physician got his start through his employment by a fraternal order, which he promptly discarded as soon as his presence in town was advertised.

Then came the insistence of State Departments of Health that all cases of contagious diseases should not only be reported, but also that standard treatments should be given. Doctors complied by reporting their cases and then leaving all the details of "quarantine" to the helpless health officers, and secretly condemned them for the restrictions which they imposed on the family. It was then the rule that everybody in a family was quarantined, with an armed guard at the front door.

Later, the subject of "State Medicine" became the burning question under discussion,—and by it was meant any participation of an official body in the management of a case. However, the experience of one-third of all the active physicians as medical officers in the World War was a convincing demonstration of the necessity of coöperation among physicians; and the last doubt disappeared when many an individualistic physician found himself involved in an expensive lawsuit because of his refusal to call a consultant in fracture cases. The x-ray became the all-seeing eye which revealed the doctors' mistakes, and forced him to coöperate with his fellows.

The medical profession of New Jersey is rapidly solving the problem of "State Medicine" by asserting its leadership, and accepting the challenge that organized physicians are unable to devise a substitute for the dominance of State officials in giving all forms of scientific treatments to those persons who have low incomes or no incomes at all. As is usual in all violent arguments, the dispute over State medicine is nearing a satisfactory settlement by the process of defining the exact scope of each participant in medical service. The State Department of Health of New Jersey is working in harmony with family doctors; and the duties of visiting nurses have been defined according to standards set up by The Medical Society of New Jersey. The Emergency Relief Administration lived up to its agreements with the Medical Societies; and the Federal officials are now permitting medical leaders to devise their own methods of giving medical service to those of low incomes.

When one compares the present emergencies in the distribution of efficient medical services with conditions which existed in the decade of the nineties, there can be no doubt that the medical profession will solve the newer problems in medical practice as satisfactorily as they solved the more difficult problems of forty years ago.

Bulletin of the A. M. A.

The American Medical Association has introduced four innovations in its "Bulletin":

1. To issue it weekly, instead of monthly.
2. To bind it with the Journal as a "Supplement" that is bound in the middle of the Journal, and has its own index and paging.
3. To mail it to all subscribers of the Journal as well as to Fellows of the American Medical Association.
4. To change its purpose from "Official Organ of the House of Delegates", to "Devoted to the Organizational, Business, Economic, and Social Aspects of Medical Practice".

The first number of the Bulletin in its new form is a part of the Journal of January 2, 1937, and announces the following plans:

1. A series of articles on the A. M. A. building and the activities that it houses.
2. A series of studies of rural medical service in the several states.
3. A series of reports on the "Annual Sessions of the Secretaries and Editors of the State Medical Societies".
4. A series of articles on the business aspects of medical practice, including the investments and equipment of physicians, and their collection agencies, telephone service, and credit-rating bodies.

The Bulletin in its new form will supply the Journal with a department of information which will be of essential service to the members of The Medical Society of New Jersey.

Bulletins of the County Societies

The Journal has adopted the practice of quoting from the Bulletins of the county societies (see page 56). The principal difficulty in carrying out the plan is the wealth of information contained in them. While many of the activities are reported in the department of "County Society Reports", the record of many more of equal value are to be found only in the Bulletins.

The Publication Committee suggests that county societies exchange their Bulletins; and that each one send a copy of its own to every President and Secretary of every county society, whether or not the society publishes its own Bulletin. Each Bulletin will be an inspiration that those having no Bulletin shall establish one at once for the information and inspiration of its members.

Read Your Journal

We have about decided that the reason why doctors throughout the nation do not read their journals as thoroughly as they should is that the journals contain *too much* of value, rather than too little. Let us analyze our own Journal mathematically.

Each issue of The Journal contains about sixty pages of solid reading.

Each page contains 800 words, making 48,000 words to be read each month.

It is a rapid reader who can read 200 words per minute. Therefore, he would have to read intensively 240 minutes, or four hours, in order to skim through each Journal. Now really, is it right to expect a member to apply himself to the task, month after month?

The New York Times hired a literary girl to read one of its issues from end to end, and she was busy for two or three days at the task. How much of the newspaper does an average man read? Not much, and yet the average commuter on the trains has an excellent grasp of the world's daily history.

We venture the opinion that the proportion of our medical journal which is read by the average member is far larger than the fraction of the New York Times that is read by the commuter.

The average doctor says that he reads that part of The Journal which interests him. This means that every member reads something important in each Journal. We doubt that any member has ever read an issue of the A. M. A. Journal from cover to cover; yet many a medical leader confesses that the first column to which he turns is "Tonics and Sedatives", because it has a *human* as well as a *medical* appeal.

Most readers of our Journal turn first to the scientific articles. Few read *all* the medical and surgical articles. They lay The Journal aside with the anticipation of reading one or two of the articles which deal with subjects which they can apply at once in their daily practice.

Our Journal has two distinct values:

1. As a newspaper on medical events relating to New Jersey.

2. As an encyclopedic storehouse of the records of The Medical Society of New Jersey and its component county societies.

Few doctors have an encyclopedic knowledge of medical affairs in New Jersey at instant service,—they turn to The Journal for confirmation of their opinions. Better than reading every issue of our Journal and then casting it aside, is the habit of filing The Journal for future reference. We in the editorial office wear out each Journal in six months thumbing its pages in order to answer inquiries regarding Society actions which are equally available to every member if he has preserved his Journals.

It is a healthy sign that members are constantly writing to the Executive Offices for information that appears in the Journal and nowhere else.

History and Prophecy

The *history* of the first half of the present official year of The Medical Society of New Jersey is a *prophecy* that a new standard of attainment will be revealed in the annual reports of its officers and committeemen to the annual meeting in April.

Those who assumed office last June were the inheritors of a program in which a major feature was that every doctor in private practice should support his county medical society in its capacity as the *medical adviser of the community*. The program of The Medical Society of New Jersey recognizes the principle that every case of sickness, or threat to health, affects public welfare and general prosperity; and therefore every practicing physician should assume the leadership in preventing as well as curing sickness and ill health among those who consider him to be their Family Doctor.

Physicians react to the principle in varying degrees. All accept it as a cold, *intellectual* fact. A large group show an *emotional* reaction to the extent of saying, "Somebody ought to do something about it". A smaller group, now rapidly becoming larger, is developing the *will* to take the initiative in applying the principle in their daily practice.

The resolutions passed by county medical societies and the projects adopted reflect the collective opinions of the individual members who have studied the principles of their relations to the public, and have developed a sense of duty to put those principles into action. About one thousand physicians are now listed as officers and committeemen of The Medical Society of New Jersey and its component county societies, and are giving serious study to the public relations involved in the practice of medicine. This great army of interested physicians can accomplish whatever they undertake.

Waves of influence originate in the State Society and spread in widening circles that impinge upon the county societies; and then upon the individual members. This important fact must be realized,—the wave is only a pleasant ripple until it strikes every member of the county societies, and sweeps him onward with an irresistible force.

The dominant problem of The Medical Society of New Jersey is that of inspiring the

members to put its plans into action. Formerly the officers were content to stop when they adopted principles of action. A great forward step was that of securing the approval of those principles by the county societies. The State officers are now extending their circle of influence so as to reach every individual member.

One of the most outstanding accomplishments of the State Society during the past three years has been the development of a system of advisory services to the county societies. A constant stream of influence flows through the Executive Offices to the county societies, and back over the same route to the State officers and committeemen. In addition, the members of the President's Cabinet are making regular visits to the county societies, and inspiring their members to exemplify the standards of action that have been developed as a result of an intimate knowledge of the present state of medical practice in every part of the State. The State leaders realize the wide variation in the needs of the several counties, and commend any county society that seriously undertakes to solve its own problems in its own ways.

The annual reports of each officer and committee of the State Society always contain a prophecy of future action, based upon the response of the members during the past year. The members will anticipate the coming reports with a keener interest than ever before, because they have been kept informed of what has been undertaken and accomplished.

Facing Facts in the Councils of Organized Medicine in New Jersey

Within the last few years many programs designed by political and social agencies to improve conditions in the various fields of effort have been offered as a panacea. Many of these programs had proper general aims, but the immediate objectives were often obscure and the stated general aims were too complex and inclusive to permit of attainment. An extended period of experiment and a cumulative basis of achievement in the integral parts of these complex objectives is necessary to work out a practical system of medical service.

Experience constantly teaches one to be on the lookout for the *unexpected* developments which crop up periodically and require frequent and often considerable revision of the original plans and program. Plans to meet these new conditions must be developed out of one's past experiences as one proceeds, and certain basic considerations must always be kept in mind, so that the fundamentals shall not be allowed to become obscured by the less important ones.

I refer to the available time, budget, and personnel, and also the *relative urgency* of the needs to be met. Many desirable things are less urgently needed at a given time than are certain others.

The real basis of successful achievement is to utilize most effectively and economically our available time, funds, and personnel to accomplish our aims. This process requires constant and serious consideration of the relative values of the activities carried on, and the consideration of these values are definitely influenced by many factors, i. e., intelligence, emotions and strategy in coördinating these factors in the individuals concerned.

It is a common error to regard separately the terms *quality* and *quantity*. In reality, quality always exists in some quantity which varies from time to time. For example:

1. A white shirt is less white when worn the second day. A healthy person may be "more" or "less" healthy;

2. A hazard to health may be more or less dangerous;

3. A remedy may be more or less effective than another in any given case.

Theoretical programs for the solution of our problems provide a good beginning when experienced advisers are not available; but wisdom is accumulated out of practical efforts in overcoming the unexpected outcomes with which theory is usually untroubled.

Medical practice in the U. S. A. is founded

upon the wisdom which comes from knowledge, *plus* experience. This wisdom has been accumulated in the practical application of the sciences by men whose names are known to every physician, as well as to other professions; and they have brought the application of this accumulated knowledge and skill to the high levels of an art. Only so long as we have physicians who practice the art of medicine can the quality of medicine be constantly improved and a sufficient number of true disciples of Aesculapius be trained to carry on his traditions in the professional practice of medicine.

These high standards are the first essential to preserve health—not the quantity of medical technicians which can be produced en masse for geographical distribution at a predetermined income and predicated upon a standardized product to be produced in the medical school.

Certain European countries have such systems. The people of the United States already have something far better, but none would claim that the distribution of medical services, good as they are, in the U. S. A. cannot be improved at this time. It can and will be. Not all graduates in medicine do or can practice the true science and art of medicine, and the abuses generally occur among those medical graduates who would make a commercial business of medical practice; not among those who follow the precepts and example of those colleagues who are fit to be regarded as the artists of our noble profession.

A more extensive knowledge and use of time-saving and efficiency devices which make it possible to increase our service, need in no way conflict with the quality of our professional practice or conduct; rather would the distribution of these services be extended and improved by such methods.

Organization to provide better opportunity for more patients and for physicians properly qualified to serve them at reasonable cost is desirable and even necessary in such a complex and organized society as that in which we live today. Our aims must be clear to us, and be clearly stated to the public; our objectives really desirable and attainable; our motives unquestionably honest and honorable; our criteria of success valid; and our achievements commendable and commensurate with the expense, effort, and wisdom involved.

Any system of medical practice which meets these demands is assured of a well-deserved place in the sun.

LeRoy A. Wilkes.

The Social Security Act in New Jersey

The great value of the administration of the Social Security Act in New Jersey is its provision for setting up facilities for diagnosing and treating conditions which do not generally receive sufficient attention.

First, the establishment of centers for diagnosis and treatment.

Secondly, aid to family doctors in giving the proper attention to these patients.

Both methods are being followed in New Jersey, and both are equally necessary, although the emphasis is usually on *centers*. The Middlesex County Medical Society is emphasizing the office of every family doctor as a recognized center for diagnosis and treatment.

It is well that both methods are in process of demonstration. As a matter of fact, the ultimate objective of the public "Centers" is to inspire every doctor to make his office a health center for all classes of patients.

ORIGINAL ARTICLES

THE OCCIPITO-POSTERIOR POSITION AND ITS MANAGEMENT

MATERNAL WELFARE—ARTICLE NUMBER TWELVE

By Raymond T. Potter, M.D., F.A.C.S., East Orange, N. J.

The occurrence of the occipito-posterior position during pregnancy and as a complicating factor in labor is sufficiently frequent (20 per cent to 30 per cent of all vertex presentations) to warrant a brief consideration of it in the Maternal Welfare Department of The Journal.

In the latter part of pregnancy, the position may be diagnosed and, if desired, attempts may be made to change it to an occipito-anterior if the fetal head has not descended too low into the maternal pelvis. If successful in changing the position, it is well to have the mother wear an abdominal binder, padded on either side below the navel, to preserve the corrected position. The fetal heart should always be checked after rotation to make sure the fetal circulation has not been embarrassed by the maneuver.

Many of these position are not diagnosed until labor has supervened, or, indeed, are never suspected, since they rotate spontaneously and are born in an anterior position. The cases of spontaneous rotation do not necessarily complicate labor except, perhaps, to prolong it. The persistent occipito-posteriors, however, do complicate labor and preclude its normal termination. The variations of the usual mechanism are due to extension of the fetal head rather than flexion; and the fact it has to rotate through 135° instead of 45°.

Most fetal heads enter the maternal pelvis in the transverse diameter of the inlet. The majority flex well, follow the normal mechanism and rotate anteriorly. The others, not considering the brow and face presentations, follow either of two false mechanisms: (1) descent with neither flexion, extension or rotation and come to a transverse arrest; (2) become extended, rotate posteriorly and remain so. It is the latter group we will consider.

SIGNS OF OCCIPITO-POSTERIOR POSITION

If not previously diagnosed, the presence of an occiput-posterior is usually suspected when:

1. The fetal "small parts" are prominent in either side of the maternal abdomen or are definitely palpated anteriorly.
2. The fetal heart sounds are heard well out in the flank (with marked extension of the head, and the chest forward, the heart sounds may be heard loud and distinct near the midline).
3. Onset of labor is delayed.
4. The membranes rupture early.
5. The patient complains of excessive pain in the sacral region.
6. The first stage of labor is prolonged and, having reached a stage of dilatation, the cervix does not continue to dilate.
7. Despite hard and active pains, the fetal head refuses to continue its descent in the pelvis.

MANAGEMENT OF THE CASE

When the occipito-posterior position is known or suspected, the patient should be given nourishment frequently, consisting of small amounts of soft diet and fluids; moral support, with plenty of encouragement; and adequate rest. Resting is important, for proper sedation, resulting in sleep and rest, permits the expectant mother to recoup her strength, relaxes her muscles, and favors cervical dilatation.

If the membranes have not ruptured spontaneously, artificial rupture is advised if the cervix is three or more fingers dilated, if the membranes are tense over the fetal skull, or if there is very little fore-water.

No attempt to deliver the baby should be made until the membranes have ruptured and the cervix is fully dilated or dilatable, and retracted or retractable.

Very often, in these cases, the cervix does not completely dilate and can not retract. The head, in its extended position, does not descend sufficiently to cause full dilatation of the cervix or permit retraction of it. Given time, however, the cervix does become sufficiently soft and dilated to allow any one of several procedures for flexing and rotating the head. This accomplished, the presenting part will descend and complete the dilatation.

Before attempting to deliver the baby, be sure of its position. Gain what information is available by abdominal palpation, i. e., the position of the fundus, the site and intensiy of the fetal heart, prominence of the small parts, etc.

Vaginal exploration should be made with the patient on the delivery table, properly prepared and draped, anesthetized, and the operator wearing a sterile gown and gloves. In these cases the extended head fills the posterior aspect of the vagina rather than the anterior portion. Feel for the sagittal suture and the fontanelles, or for the posterior ear. Make sure of the position of the fetal body in relation to the head so that rotation of the body may be in the proper direction, thus avoiding undue and excessive torsion of the baby's neck. Be sure to catheterize the patient.

CORRECTIVE PROCEDURES

The following are some of the more common and accepted procedures in these cases:

1. *Version.*—This is one of the most difficult and dangerous operations in obstetrics and should be attempted only by the most experienced and adept operators. The indications for version in occipito-posterior positions are few, we feel; and this operation should be employed only under exceptional circumstances and not as the operation of choice.

2. *Cesarean Section.*—This is indicated when the head is at the brim of the maternal pelvis and shows no inclination to engage, or when engaged at the brim, there is no dilatation or descent after a test of labor. Even with cervical dilatation after a trial labor but the head still "floating", Cesarean section is preferable to high forceps or version. No attempt should be made to deliver through the normal route if there is suspected the need for Cesarean operation.

3. *Manual Rotation.*—Many posterior positions can be corrected by manual rotation, and it is worth trying before resorting to more complicated methods. The success of this procedure and its ease of accomplishment depend upon the position of the head in the pelvis, and its size in relation to the birth canal. The size of the operator's hand may also be a factor.

With the head in mid-pelvis, i. e., between the brim and the ischial spines, the shoulders are at, or just above, the brim. Rotation of the head alone is not sufficient usually, since the position of the body is unchanged and, when released, the head will return to its original position. To be successful, one should place his fingers in front of the posterior shoulder and rotate it to the desired oblique diameter. Kristeller pressure on the abdomen will tend to fix the baby in its new position. Labor may be allowed to proceed normally, or be terminated by the use of forceps.

When the head is at, or below, the level of the ischial spines, the shoulders are engaged and below the pelvic brim. Rotation of the body is more difficult now, for, in order that it may be turned, it must be pushed up out of the pelvis. Usually this is not necessary, for the head can be grasped between the thumb and the third finger over the parietal bosses, gently flexed, rotated anteriorly, and held while forceps are applied. Traction is then made to fix it in its corrected position. In these procedures use the left hand for right positions and the right hand for left positions.

4. *Forceps Rotation.*—Failing in, or unable to execute, manual rotation, one may use forceps rotation. There are numerous operations for this purpose, such as:

a. Single application, rotation and delivery with the Kielland forceps.

b. Double application, or the Scanzoni maneuver.

c. Reverse, single application of the classical forceps (Tucker-McLean, Elliott, Simpson, etc.) with rotation followed by extraction.

d. Rotation with one blade of a forceps and the hand.

e. Manual rotation of the head to a transverse position followed by single application of Kielland or classical forceps and rotation completed by forceps traction.

FORCEPS

Space permits but a brief description of the more common of these operations. The Kielland instrument is very useful in these cases. Since these forceps have no pelvic curve, rotation and delivery can be accomplished with one application but the traction, after rotation is effected, must be *made downward* until the occiput is well under the symphysis. Early and wide episiotomy is often necessary to save the perineum and anus from trauma. In doing the Scanzoni maneuver, apply the left blade first in right positions and the right blade first in left positions. When doing the rotation, swing the handles of the forceps through an arc of a circle the center of which is the fetal head. *Do not twist* them on their own long axis. After rotation, give a final, gentle tug to fix the head, and remove the blades. In reapplying them, insert first the blade to the lateral side of the head, i. e., the right blade in right positions and the left blade in left positions.

Before rotating or making traction with forceps, always check their position in relation to the fetal head to ascertain if they are properly applied. To do this, find if the sagittal suture is equidistant from the forceps blades; and when the head is in anterior position, the lambdoid sutures are parallel with, and slightly above, the blades.

Manual rotation to a transverse position and then a single application of forceps is a method popularized by Williamson. After turning the head transversely, the posterior blade is placed with the concavity of its pelvic curve in the direction of the occiput. The anterior blade is then placed by inserting it along the vaginal floor with the concavity of the cephalic curve upward and, with the handle well depressed, sweeping the blade over the baby's face until it reaches its proper place under the symphysis, and the handle is in juxtaposition to its fellow. Traction is made downward until complete rotation is accomplished and the occiput appears under the symphysis.

OCCIPUT-POSTERIOR DELIVERY

Some obstetricians, on occasion, advocate delivering the head as an occiput-posterior. Whether or not this is good obstetrics depends on the individual point of view, and the indications for such a delivery.

THE CONSERVATIVE TREATMENT OF ECLAMPSIA

A STUDY OF 148 CASES

By JAMES R. McCORD, M.D., Atlanta, Georgia
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Read before the General Session of the 170th Annual Meeting of The Medical Society of New Jersey, at Atlantic City, June 3, 1936

I think that a mortality rate of 6.75 per cent in a series of 148 consecutive cases of eclampsia is low and that certain information which has been obtained merits discussion.

The value of prenatal care in the prevention of eclampsia is often discussed. Prenatal care should mean meticulous and frequent supervision. That it often does not is evidenced by this group of women for 53.47 per cent attended the prenatal clinic one or more times. The responsibility for the failure of prevention in this series must be placed largely upon the lack of coöperation, the low intelligence and the economic status of the women, and a minor responsibility upon the physicians. The prevention of eclampsia is not always possible.

It has long been known that eclampsia occurs with greater frequency in young women. The age groups of this series, however, emphasize the necessity for the frequent examination of young pregnant women. The age of 73.61 per cent of the women was twenty-one years

or less, and that of 62.5 per cent was nineteen years or less. Because of the large number of young women, it is to be expected that 74.3 per cent were primiparas.

Postpartum eclampsia occurred in 22.22 per cent of the cases. I think I am conservative in saying that, all in all, postpartum eclampsia was much less severe than the other types.

The fact that 95.83 per cent of the women had a hypertension before they had convulsions, again emphasizes the great value of the blood pressure instrument in detecting early toxemia. At this point it should also be emphasized that an elevated blood pressure, either systolic or diastolic, is, in nearly every instance, the first evidence of a toxemia.

Several years ago, the first ninety-one cases in this series were reported. The charts of four women who died were lost and have never been found. In discussing mortality, I add these four deaths to the 144 cases in this study. Ten women died—an uncorrected mortality of 6.75 per cent. The four deaths mentioned cannot be analyzed. Some remarks as to the remaining six follow:

One death was probably preventable. The patient refused all advice and treatment.

Accidental separation of the placenta was a complication in two deaths. One of these deaths was probably not preventable. In the other, the woman gave us complete coöperation, and an error in judgment was the probable cause of her death.

There was another death where the woman cooperated fully, and an error in judgment was a contributory factor in her death.

One death occurred before delivery and sepsis was the cause of one death.

Some method for the induction of labor was used in 48.61 per cent of the cases. The methods were as follows:

Rupture of the membranes (with and without the use of castor oil, quinine or pituitary extract)	53
Bag	9
Bag and catheter	3
Catheter	2
Rupture of the membranes and bag	2
Rupture of the membranes and catheter	1

Conservative therapy,—namely, morphine, magnesium sulphate and intravenous dextrose, —will usually control convulsions, coma, and shock. In most instances, labor should not be induced until this has been done. I think that recognition of this fact has a great deal to do with lowering the death rate.

Delivery was spontaneous in 86.01 per cent of the cases, that is, 123 of the 144 women delivered themselves. Two classical Cesarean sections were done, one because of a contracted pelvis and the other, early in the series, without a sound indication. A Cesarean section has not been done on our service for eclampsia or preëclampsia since January, 1928. There were eighteen forceps operations in the series. Fourteen of these were low forceps and four were mid forceps. The indications for these operations were:

Arrest of head on perineal floor	6
Occipitoposterior positions	5
Inertia	2
Deep transverse arrest	1
Dead mother; living baby	1
No indication	3

I have long been of the opinion that women are subjected to unnecessary risks in the interest of the baby. In this series, 76.54 per cent of the babies were living when discharged from the hosptal. However, 24.13 per cent of these were premature babies and it is probable that the mortality in this group was high. Of the babies discharged, 52.41 per cent were term babies. Only 23.44 per cent of the mothers left the hospital without a living baby. A few of the causes of infant deaths as determined by autopsy were:

Cerebral hemorrhage	4
Premature separation of the placenta	3
Syphilis (Treponema pallidum found)	2
Prematurity	2

Because of a crowded ward, many of these women were allowed to leave the hospital too soon. Blood pressure readings were made on 136 women at the time of discharge. Hypertension was present in 36.76 per cent. The danger of chronic hypertensive and renal diseases following pregnancy toxemias is a real one and is always to be considered in any expectant plan of treatment for preëclampsia. I do not believe that the expectant plan of treatmen for severe preëclampsia is ever justified.

Labor should be induced promptly and the woman allowed to deliver in a safe, sane and conservative manner. The duration of the pregnancy should not influence this decision.

Increasing experience in our clinic causes me to believe that study of the eye-grounds, by one experienced, gives us the most information when evaluating the various toxemias of pregnancy. The examination of the eye-grounds in this series has been divided into two periods: the first, in which the examinations were made by several men; and the second, in which the examinations were made by one man. During the first period, pathologic changes were observed in 39.28 per cent, and during the second period, they were found in 64.28 per cent. I quote from a recently published paper of Dr. Alton V. Hallum, who studied the eye-grounds of 300 hypertensive pregnant women on our service:

1. I think that the ophthalmoscope should be rated next to the sphygomanometer as an instrument of diagnostic importance in the management of a case of hypertensive toxemia of pregnancy.

2. Generalized narrowing, and localized spastic constriction of the retinal arterioles are the earliest changes; retinal edema, hemorrhages and exudates appear later if the toxemia progresses in severity.

3. When hypertension develops or increases during pregnancy, careful watch should be kept for angiospastic lesions of the retinal arterioles. Pregnancy should be terminated if the progress of these lesions cannot be controlled by conservative measures, and certainly before the onset of retinitis.

4. The arterioles may regain their normal caliber if there is a reduction of the blood pressure to normal sufficiently early.

5. The frequency and degree of eye changes closely follow the severity of the hypertension.

6. The frequency of eye changes tends to increase with the parity, showing the accumulative cardiovascular-renal damage done by the repeated pregnancies.

In conclusion, I would say that the results obtained in this study are a much more eloquent argument for the conservative treatment of eclampsia than it is possible for me to make.

Atlanta, Ga.

DIAGNOSIS OF HIP DISABILITIES IN CHILDREN

By HERBERT TAYLOR, M.D., F.A.C.S., East Orange, N. J.
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Read before the Section on Pediatrics at the 170th Annual Meeting of The Medical Society of New Jersey, June 4, 1936, at Atlantic City.

The rôle of the orthopaedic surgeon is to prevent deformity as well as to correct it when found. The frequency with which one is confronted with disabling hip conditions in children indicates the need for more accurate diagnosis, and the adequate application of that information obtained by methodical and conscientious examination. Our fund of knowledge is greater today than ever before; and when properly applied, it should result in the early recognition of these conditions before irreparable damage has been done. I believe that too much dependence is placed upon the wealth of the laboratory at our disposal, and the roentgenologist. Too often this tends to obscure our power of observation, our "tactus eruditus", and the ability to form our own opinion.

EXAMINATION

In our physical examination of children, let us not be so hurried that we fail to elicit a careful family and past history, as well as the immediate circumstances surrounding the present illness. A clothed child cannot be properly examined. When possible, the child should stand, walk, sit, and lie down before the examiner, thus giving adequate opportunity for observing the posture, the gait, the presence or absence of a limp, the level or inclination of the pelvis, the curves of the spine, the contour of the hips and buttocks, and the gluteal folds.

With the patient prone on the examining table, flexion deformities of the hip quickly assert themselves. The buttocks may be gently palpated, and the region of the hip joint exam-

med for capsular distention and displacement of the femoral head. In this position, the amount of hyperextension and rotation of the hips can be determined, as well as the flexibility of the lumbar spine.

With the patient in the supine position, flexion, rotation, abduction, and adduction of the hips can be checked. The amount of flexion deformity in one hip can be accurately judged by gently flexing the other hip on the abdomen until the pelvis lies flat.

The importance of muscle spasm cannot be overestimated, and the value of this symptom can be judged only by the experience of the examiner gained in the gentle manipulation of many hips.

In the presence of a distended joint capsule, the aspirating needle is frequently called for, as this may determine the need for immediate surgical intervention.

To complete our investigation, the resources of the laboratory are called upon to give us our blood picture, sedimentation rate, Wassermann, Mantoux, and if necessary, the results from a biopsy.

Finally, the roentgenogram should be studied for corroboration of our tentative diagnosis which should by this time have been made.

ROENTGEN DIAGNOSIS

In adjudicating the importance of the roentgen findings in a child's hip,* we must bear in mind that the centers of ossification in the femoral head can rarely be visualized before the tenth month; those of the great trochanter from the third to the ninth year; and of the lesser trochanter from the eighth to the tenth year. The union of the head, neck, and trochanters, as well as the acetabular elements derived from the ilium, ischium, and pubis does not occur until the seventeenth to the twentieth year. Therefore, before maturity, roentgenograms should include both hips on the same film for purposes of comparison and to avoid errors due to the epiphyses.

If anteversion of the head and neck is suspected, two films should be made,—one with the feet inverted equally, and another with eversion. Variation in the joint space will frequently give us the first definite indication of trouble in the hip joint. When the capsule is distended, the roentgenogram as a rule will detect this. Thinning of the cartilage is another sign and as a rule is accompanied by certain definite clinical signs; erosion, decalcification, and bone destruction may follow.

The acetabular outline, after the first year or two of life and until the eighteenth year, may be irregular, but this need not be viewed with alarm in the absence of symptoms. A subluxation may be determined by a break in the curved lines of the femur and the pubic portion of the pelvis. In a child, the normal angle of the head and neck of the femur with the shaft is about 125 degrees. Less than this is coxa vara and greater, coxa valga; of which the latter is the rarer and usually follows some condition causing loss of weight bearing.

CONGENITAL DISLOCATION

In congenital dislocation of the hip, diagnosis is frequently not made until the child begins to walk. As the early reduction of this dislocation is important, we must have certain definite signs to aid us. Careful measurements, the presence of "telescoping", the change in the gluteal folds, actual feeling of the femoral head as it is rotated under the examining hand, and the Trendelenburg sign, are of the utmost importance. In the Trendelenburg sign, with the patient standing, the pelvis drops on the *sound* side when the patient puts the weight on the *affected* leg. This is due to the functional impotence of the glutei. Roentgenograms must be taken with considerable care. The position of the child must be carefully determined with accurate placing of the pelvis and lower extremities, and centering of the tube.

Putti believes that there are three signs of dislocation to be looked for in the early roentgen diagnosis of this condition:

1. In unilateral cases, the nucleus of the epiphysis is absent on the dislocated side, and present on the normal side.

2. The top of the femur is some distance from the floor of the acetabulum and is higher than normal.

* Brailsford, James F.: The Radiology of Bones and Joints, 2nd Edition. William Wood & Company, Baltimore. P. 181 et. seq. 1935.

3. The roof of the acetabulum is sloping.

After the first year the diagnosis becomes progressively easier. The child is apt to walk later than is normal, and in the unilateral types there is a characteristic limp. In the bilateral types, the lordosis is marked and the waddling gait can hardly be missed. We must keep in mind the thought of familial predisposition, and also that the condition is more common in females.

ACUTE INFECTIONS

The acute hip joint infections may be found at any age. Some produce symptoms out of all proportion to the demonstrable pathology.

The diagnosis of *acute suppurative epiphysitis* and acute osteomyelitis is materially helped by a careful history. Frequently secondary to upper respiratory tract infections, tonsilitis, or otitis media, we may have sudden pain referred to the hip joint. Sever pain, muscle spasm, and limitation of motion with rise of temperature may follow and will require a blood count and sedimentation test, and if the capsule is distended, perhaps aspiration of the joint. The infection may continue for days with a mild temperature with local symptoms severe enough to cause muscle spasm and deformity, and then resolve without further disturbance. Again, it may go on to suppuration, and we will have pus formation, either intracapsular, or involving the trochanteric region with an acute osteomyelitis. This type of case will require incision and drainage, and may go on to a general septicemia. This is one condition in which the early diagnosis is not aided by the roentgenogram; we must rely chiefly on the physical signs and laboratory tests.

Frequently children are sent in with a diagnosis of polio, when they are in fact suffering from an acute osteomyelitis. Here the use of the aspirating needle in one of two places, the spinal canal or the hip joint, might alone decide the question.

PERTHES' (OSTEOCHONDRITIS DEFORMANS JUVENILIS)

This disease, with sundry and manifold names, is found frequently enough to warrant our recognizing it when we see it. It is, as the name suggests, a deforming osteochondritis of the femoral head; and like tuberculous coxitis, it has an insidious onset with some pain, spasm, and a limp, all of which are apt to be periodic. Unlike tuberculosis, it is self-limiting, and the symptoms subside after a year or more with a characteristically deformed femoral head, and a limp due to shortening. Like tuberculosis, it may cause referred pain in the knee from a branch of the obturator nerve. This condition is usually unilateral, most common in boys between the third and the fifteenth year, and associated frequently with trauma. We must differentiate this disease from tuberculosis and slipped epiphyses.

TUBERCULOSIS

A diagnosis of tuberculosis cannot be made unless the tubercle bacillus is found in the joint fluid, or by guinea pig inoculation, which in turn induces demonstrable lesions; or the result of biopsy shows tuberculous tissue. As the joint involvement is probably secondary to lymphatic involvement, we must examine the chest, and a roentgenogram of the lungs, as well as a Mantoux, will help to clarify the situation.

Treatment should not be started until a diagnosis is made as the prolonged immobilization of the joint causes further decalcification, muscle atrophy, and limitation of motion.

Published reports from the New York Orthopedic Hospital show that many cases go unrecognized and improperly treated for years; while other cases not tuberculous are subjected to immobilization and months of unnecessary and inappropriate treatment. As a result, many of the published statistics of this disease have been unreliable.

The roentgen findings, as a rule, are definite. We find first a distended capsule, followed by a thinning of the joint cartilage; then a narrowing of the joint space and decalcification; and finally erosion and destruction, nature's attempt to fuse the joint and stop motion.

SLIPPED FEMORAL EPIPHYSIS

This is one of the common disabilities occurring during the adolescent period and accounts for many of the cases of coxa vara. It is more

common in the male. Disease and trauma are equally blamed as causative factors, but it has been my experience to find most of my cases attributable to disease. It is frequently associated with the hypo-pituitary type, particularly when bilateral. In the "pre-slipping" stage the earliest symptom will be dull aching in the affected hip, which is relieved by rest. At this stage, the roentgenogram will show a thickening through the width of the metaphysis, and an increased definition or outlining of the metaphyseal border of the epiphysis.

POLIOMYELITIS

Diagnosis in the pre-paralytic stage must be made on the signs of meningeal disturbance. Fever of unexplained origin, headache, neck rigidity, mental irritability, and photophobia will suggest this condition. At this stage, a lumbar puncture will not only be of diagnostic value, but a distinct help as a therapeutic measure.

SCURVY

This constitutional disease arising from dietary errors frequently presents confusing bone and joint symptoms. It may be mistaken for acute osteomyelitis, or even malignancy. A careful history (the age period is under eighteen months as a rule), multiple joint involvement, absence of fever, subcutaneous hemorrhages, swollen spongy gums, anemia, and loss of weight, will in most cases point the way to a diagnosis.

RICKETS

This condition, as a rule, should not furnish much confusion in arriving at a diagnosis. The characteristic physical signs, corroborated by the roentgenogram, are usually satisfying. We may have it combined with scurvy.

SYPHILIS

This will occasionally cause an epiphysitis in the hip. The positive Wassermann, the roentgenogram, and the ruling out of other conditions by the clinical picture will help us here.

HEMOPHILIA

Occasionally a hemarthrosis in the hip will be found in these types, but it is more often to be found in the knee or ankle.

FRACTURES

Injury to the hip resulting in unrecognized fractures has gone undetected, and has resulted in deformities of the coxa vara type. Roentgenograms taken at the time of injury will be of help to us here.

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A PRESENTATION OF CASES REQUIRING PLASTIC REPAIR

By Lyndon A. Peer, M.D., Newark, N. J.

Read before The Society of Plastic and Reconstructive Surgery.

The word plastic is derived from the Latin *plasticus,* which is translated, to build up or restore. In surgery, it means to build up tissue, or restore lost parts of the body. Plastic surgery is often divided into *cosmetic* and *reconstructive* surgery, but the two types overlap to such an extent that almost every case presents a combination of disfigurement and functional disability. A method of repair which corrects the disability will also improve the patient's appearance; and hence, to some extent, every reconstructive procedure is a cosmetic procedure. A few examples of this interrelation are:

1. The careful selection of skin grafts which blend well in color and texture with the adjacent skin for repair of facial deformity.

2. The elevation of depressed nasal tip, which improves both the breathing space and appearance.

3. The use of a Wolf or split graft in burn scar contractures of the hand instead of a bulky pedicle flap.

When the term *functional* disability is broadened to include *mental* disability, such conditions as flop ears, hump nose, and slight ptosis of the eyelid may properly be included, as consciousness of these disfigurements often handicaps individuals in their work. Since function and appearance in the human body are so closely related, it is quite fitting that the plastic surgeon, in restoring the use of a part, should also employ every means at his disposal to restore its normal appearance. With this thought in mind, I am presenting before the Plastic Society a number of cases with both cosmetic and functional considerations.

CASE 1. CRUSHED HEEL

A middle-aged man admitted to the Dover General Hospital in June, 1935, following a street accident in which a truck ran over his right heel. Dr. John Adams examined the patient and found a large loss of tissue over the right heel, with a compound fracture of the os calcis. Dr. Adams debried the wound, removed loose fragments of bone, and applied wet compresses. I first saw the patient in October, 1935, and at this time he had a large denuded area over the right heel extending along the plantar surface of the foot with exposure of the os calcis. The wound was granulating, but the skin margins showed very little growth tendency. The patient was completely disabled because of inability to bear any weight on the heel. (See Case 1, figure A.)



Case 1, Figure A.—Large loss of tissue over left heel with exposure of the os calcis.

A large tube flap was first formed from the skin on the anterior surface of the right thigh. Two weeks later, a paddle of skin, including the subcutaneous fat, was outlined, partially separated from the underlying muscle fascia, and resutured into



Case 1, Figure B.—Tube pedicle of skin on the anterior surface of the right thigh. A paddle of skin slightly larger than the heel defect has been outlined at the upper end of the tube.

place. (See Case 1, figure B.) This procedure was repeated at two-week intervals until the paddle could be completely detached and still receive an adequate blood supply through the skin pedicle attached to the thigh. The denuded area over the



Case 1, Figure C.—Paddle of skin and subcutaneous fat detached from right thigh and sutured to cover defect on the left heel. A plaster cast holds the left foot in position and the flap receives its blood supply through the pedicle attached to the thigh.

right heel was then debrided, the heel approximated to the thigh, and the paddle of skin with its underlying subcutaneous fat sutured to the skin margins about the defect. (See Case 1, figure C.) A plaster cast was applied to maintain the leg in position and prevent tension on the pedicle. Two weeks later the pedicle was severed, the plaster cast removed, and the free edge of the graft sutured to the adjacent skin margin over the tendon



Case 1, Figure D.—The pedicle has been severed and the upper margin of the flap sutured to the adjacent skin. Photograph taken six months after operation.

achilles. (Case 1, figure D.) The patient was last seen in September, 1936, six months after his final operation, and at this time he was able to walk normally, bearing full weight on the right foot. A normal contour was obtained by excising excess portions of the fat layer before attaching the flap.

CASE 2. BURN OF HAND

A young man referred by an insurance company with deformity of the right hand resulting from a chemical burn. The little finger was bound down in flexion by thick scar tissue to such an extent that amputation had been advised. (Case 2, figure A.)



Case 2, Figure A.—Burn scar contracture holding little finger in flexion. The thumb is also drawn toward the palm by a thick band of fibrous tissue.

The metacarpal bone of the thumb was drawn toward the palm by scar tissue, and there were web contractures between the index and middle finger, and the ring and middle finger. Under a nerve block anaesthesia all scar tissue holding the little finger in flexion was excised, and the contracted tendons of the flexor sublimus and flexor profundus exposed.

The tendon sheath was incised, the tendons lengthened, and the margins of the sheath sutured to recover the tendons. Subcutaneous fat was sutured over the tendon sheath as an additional covering, and the denuded area covered by a split graft taken from the right thigh. At the same operation, scar tissue restricting movement of the thumb was excised, and a split graft sutured over the exposed area. A pressure dressing was applied over both grafted areas with a well-padded arm board on the dorsal surface of the arm and hand. The dressing was removed on the tenth day, and the patient instructed to move the little finger and thumb at regular periods. The web contractures between the fingers were later excised and repaired by split grafts. (Figure D, case 2.) Figures B and C, case 2, show the range of motion seven months after the last operation. There is a limitation of complete extension of the little finger due to contracture of the joint capsules.



Case 2, Figure B.—Photograph six months after operation with fingers in extension. Note split graft in palm at base of right thumb and extension of little finger.

Case 2, Figure C.—Photograph six months after operation with the fingers in flexion.

Case 2, Figure D.—Photograph six months after operation of the dorsal surface of the hand with fingers in extension. Web contractures between the index and middle finger, and the ring and middle finger have been corrected by split grafts.

CASE 3. PROTRUDING EARS

A young boy eight years old referred by his doctor because of large protruding ears which made him an object of ridicule among his playmates. Curiously, although his disfigurement was cosmetic, he complained more bitterly than did any of the severely disabled patients. Measurement showed that the left ear had a greater circumference than the right ear, and, accordingly, a wedge-shaped section was first removed from the left auricle to reduce its size. One month later, a section of skin and cartilage was removed from the posterior surface of each auricle, and the ears sutured backward to give them a more normal angle with the side of the head. Figures A, B, C and D, case 3, show the condition before and after operation. The boy's mother states that his interest in school and in play with other children has increased amazingly since the operation.



Case 3.—Front and back views of the patient's protruding ears before and after operation.

CASE 4. SKULL, DEPRESSED FRACTURE

Patient 4 was admitted to the head service at the Newark City Hospital September 12th, 1933. He was struck in the forehead with a baseball bat and brought to the hospital one hour after the injury. He was not unconscious, but examination, confirmed by an x-ray, showed a large depressed fracture of the frontal bone involving both tables of the frontal sinuses. (Figures A and B, case 4.) Neurological examination was negative in spite of the large depression, there was no leakage of cerebrospinal fluid, and he remained perfectly conscious with a normal temperature. On September 14th, two days after the accident, Dr. Richard Swain turned down a forehead flap and removed a large segment of depressed bone, including both inner and outer tables of the frontal sinuses. The dura was uninjured. During the operation I made a pattern of the skull defect and removed two sections of skin, fat and fascia lata from the right thigh, each section corresponding to one-half of the pattern. (Figure C, case 4.) The epidermis was removed from the surfaces of these grafts and the two sections sutured together with catgut to form a complete pattern of the defect. This free graft, consisting of dermis, fat and fascia lata, was inserted with fascia lata next to the dura, and the forehead flap elevated and sutured in place. A light pressure dressing was applied. The wound, when exposed one week later, had healed by primary intention and all sutures were removed. The patient was seen five months after his operation (figure D, case 4) and at this time had a normal contour of the forehead. The graft could be palpated beneath the forehead skin and was apparently well tolerated by the surrounding tissues. The patient was seen again one year following operation. At this time a slight shrinkage of the graft was noted, but the forehead contour was quite presentable, considering the extensive depression which cases of this kind develop. Dr. Swain and I have used this type of graft to repair large depressions in the forehead following removal of the frontal sinuses and adjacent frontal bone at a previous operation. We have had three successful results and one failure. I have two additional cases in which I obtained a successful result, the oldest of which was seen five years after her operation. Experimental work with these dermal grafts shows no macroscopic evidence of cyst formation from glandular elements in the buried dermis, or from remnants of epithelium incompletely removed from the surface of the dermis.

(For those interested in the use of dermal grafts, reference is given to the original article of Eitner.) "Uber Unterpolsterung der Gesichtshaut", Frnst Eitner—Medizinische Klinik, Jan. 25, 1920. Page 93.

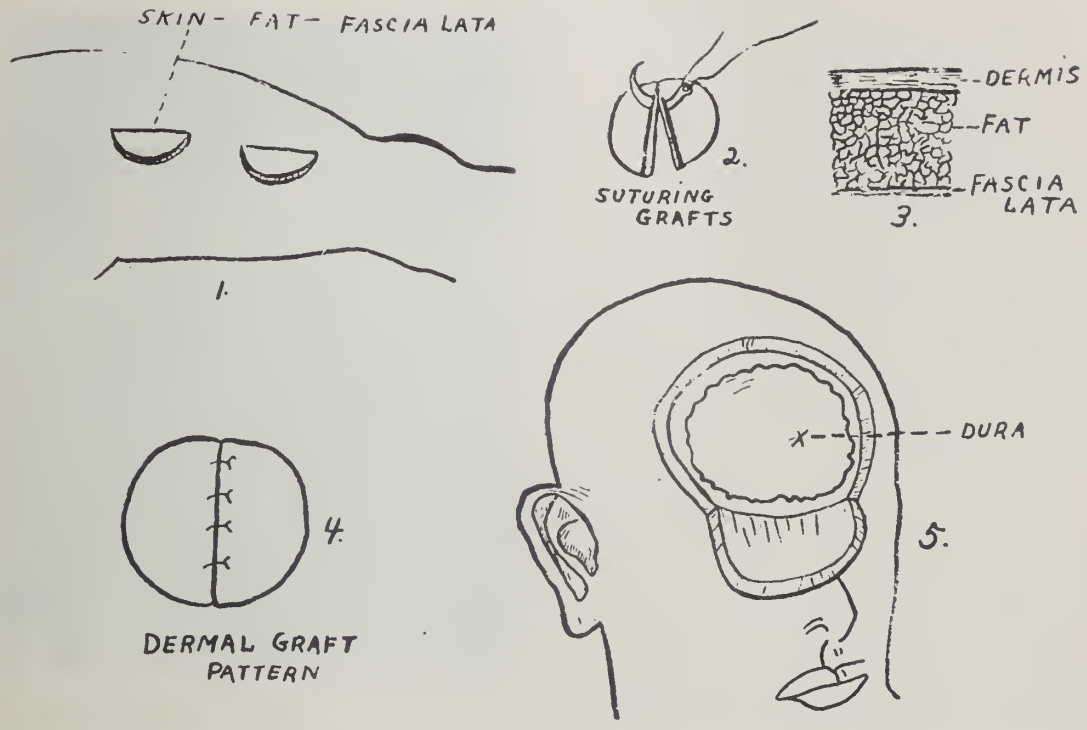
Peer and Paddock, Histological Studies on the Fate of Deeply Implanted Dermal Grafts. Accepted for publication in Archives of Surgery.



Case 4, Figure A.—Photograph of patient with large depressed fracture of the frontal bone involving the inner and outer tables of both frontal sinuses. Swelling of the soft tissues obliterates the depression.



Case 4, Figure B.—X-ray of skull showing large depressed fragment (arrow).



Case 4, Figure C.—Diagrams showing formation of dermal graft pattern.

1. Two sections of skin, fat and fascia lata outlined on the right thigh, each section corresponds to one-half of the defect.

2. The epidermis has been removed and the two sections sutured to form a complete pattern of the skull defect.

3. Cross-section of grafts showing dermis, fat and fascia lata.

4. Complete pattern ready for insertion.

5. Defect in frontal bone following removal of depressed fragment. The graft is inserted with the fascia lata next to dura, and the scalp flap elevated and sutured to cover the implant.



Case 4, Figure D.—Profile view of patient five months after operation.

CASE 5. BURNS BETWEEN THIGHS

An Italian boy ten years old was referred to me by Dr. Epstein from the surgical service of the Newark City Hospital for repair of a thick burn scar between the thighs. When he was three years old his clothing had caught fire from a piece of lighted celluloid, resulting in severe burns involving the anterior and posterior surfaces of both thighs, the buttocks, and the region about the anus. A thick band of scar tissue extended between the thighs, forming a wide shelf at the posterior margin of the anus and displacing it forward in the position of the female vagina. The burn scar between the thighs acted as a guy rope, hindering the patient's movements when walking and interfering with defecation. The presence of thick scar tissue on both thighs eliminated this region as a possible source from which to obtain skin, therefore I formed a large transverse tube pedicle from the skin of the abdomen. At a later operation one end of the pedicle was severed, a transverse incision made through the scar tissue band to obtain relaxation, and the detached end of the pedicle sutured to fill the defect. (Figure B, case 5.) Three weeks later the end of the tube attached to the abdomen was severed and sutured on the left side of the anus to obtain further relaxation of the scar tissue band. At a later operation the remaining unattached portion of the tube was opened and sutured to obtain complete relaxation of the scar tissue. (Figure C, case 5.)

The patient was seen in August, 1935, one year following the last operation, and at this time he had normal movement of the thighs and no interference with defecation.



Case 5, Figure B.—A transverse tube flap was formed across abdomen and one end sutured to fill the defect resulting from deep incision through fibrous band. Note relaxation of the fibrous band.



Case 5, Figure A.—Extensive burn scars of the thighs and region about the anus in a boy ten years old. The anus is displaced forward in the position of the female vagina. Functional disability is due to the fibrous band between the thighs which restricts movement and interferes with defecation.



Case 5, Figure C.—Final result after utilizing all of skin flap to obtain complete relaxation of fibrous band.

DIVERTICULITIS OF THE SIGMOID

By Royal A. Schaaf, M.D., F.A.C.S., Newark, N. J.

Multiple diverticula of the colon, or the acquired, "False", or pulsion variety, were first described by Cruvelhier in 1849; and to Virchow is credited the first description, in 1853, of pathological changes occurring therein. He mentioned "Isolated, circumscribed, adhesive peritonitis of the colon" which he believed to be due to inflammation in such diverticula; but he could not draw a clinical picture of the disease and thought that it was usually mistaken for disease in neighboring viscera. Habershon, in 1857, published the first account of diverticulitis in English; while Sidney Jones, in 1858, reported a case of diverticulitis which resulted in a fistulous connection between the bladder and sigmoid. Klebs, in 1869, made further observations upon the pathological changes in diverticula, and directed attention to the etiological relationship between diverticula and the blood vessels in the intestinal wall.

RESEMBLANCE TO CARCINOMA

For the next quarter century little appears in the literature of the subject beyond occasional notes in the transactions of various medical societies before which a few specimens of this character had been exhibited as pathological curiosities. There seems to have been little, if any, appreciation by the profession of the frequency of occurrence of these diverticula, or of their inherent dangers. During this period there are numerous reports of patients suffering from carcinoma of the sigmoid who lived for many years following the performance of colostomy, or who were cured by removal of the growth. Most of these, as in later instances, unquestionably must have been examples of diverticulitis causing obstruction. Recent reëxamination of many old specimens labelled "Carcinoma" lends support to this view. Moynihan was among the first to discern this resemblance; and, in 1906, he reported several cases of diverticulitis in which the "Mimicry of carcinoma was complete".

CAUSES OF DIVERTICULA

General interest in the subject of diverticulitis was revived in 1898 by Graser, who, from material obtained at autopsy, emphasized the frequency and significance of diverticula, and advanced a theory regarding their formation. He believed that chronic passive congestion of the veins of the colon, with fluctuations of the blood pressure therein, led to weakening of the orifices in the musculature through which they made their exit, thus producing "Loci minoris resistentiae" for the development of diverticula.

Beer, in 1904, strongly opposed this view and insisted upon the primary importance of weakened intestinal musculature as a prerequisite of diverticulation, ascribing an entirely secondary rôle to the blood vessels. He also demonstrated that, during life, the mesenteric border of the colon is much stronger than the antimesenteric; the reverse being true in bowel devitalized a few hours. His ideas, while running counter to those then prevailing, have since been accorded quite general acceptance.

Telling, in 1908, published a masterly article covering all knowledge of the subject then available, and reviewing 105 cases of diverticulitis which represented all those to be found in the literature at that time.

For most of our present knowledge of diverticulitis as a clinical and pathological entity we are indebted to the rapid progress in surgical technic and roentgenology during the past twenty-five years. With a few exceptions, notably those of Drummond, Telling, LeWald, Case, and Spriggs, the great majority of important contributions have been made by workers at the Mayo Clinic. In this field, as in so many others, the work of this group has been of inestimable value to the science of surgery. In 1907, William Mayo, Wilson, and Griffin published "An account of five cases in which a portion of the sigmoid was excised for obstructive diverticulitis with the formation of tumor. These proved to be the first instances recorded in which an actual demonstration of the patho-

logical change in diverticulitis was made during the life of the patient" (Mayo). In the same paper Wilson gave a description of the microscopic appearance of diverticulitis which has not yet been excelled. He also pointed out the distinction between diverticulitis and peridiverticulitis, and emphasized the importance of the latter in the severer cases.

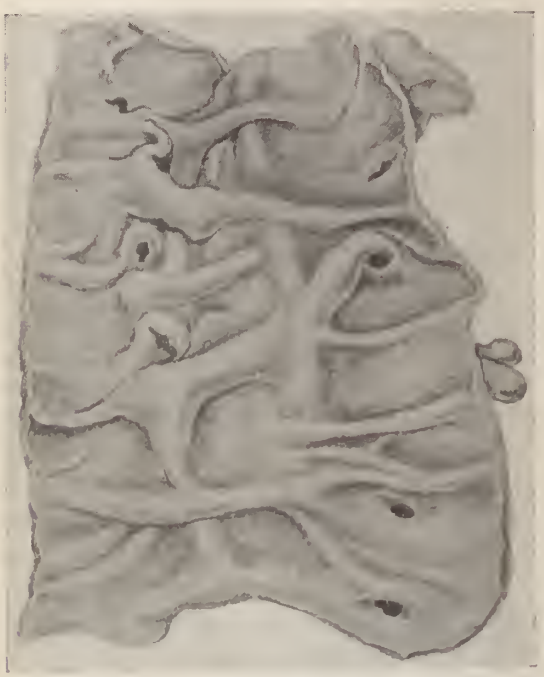


DIAGRAM 1.

Pelvic colon laid open to show the most common site for sacculi to make their appearance,—between the mesenteric and two lateral longitudinal muscular bands. *(Drummond.)*

McGrath, in 1912, published an exhaustive study of the etiology and supplemented Wilson's work in pathology; while Carmen, in 1914, reported three cases in which the diagnosis of diverticula of the colon was made by roentgenological examination. Priority in this field, however, must be conceded to LeWald, who in 1913 reported the first case, that of Dr. Abbe, in which operation for diverticulitis was performed, with a positive preoperative diagnosis arrived at by this method. From the examination of a very large amount of material, Mailer, in 1927, verified and supplemented the work of Drummond, who, in 1917, first demonstrated the remarkable uniformity with which diverticula appear in certain sites. In the meanwhile a number of surgeons at the Mayo Clinic, especially William and Charles Mayo, Judd, Balfour, Masson, Sistrunk, and more recently Rankin, gradually developed a technic for the surgical management of these cases which is now firmly established and yielding brilliant results. In pursuing the evolution of the subject through the succeeding year-books of the Clinic, one is impressed by the changing views regarding the frequency of diverticulitis, its relationship to carcinoma, the influence of obesity in its etiology, and the steadily increasing conservatism in its treatment.

NATURE OF DIVERTICULOSIS

"Diverticulosis of the colon", a term suggested by Case, denotes the presence in the colon of numerous diverticula without secondary pathological changes, and without symptoms. Diverticulosis occurs more frequently in males than in females in the ratio of two to one. It is rarely observed in persons under the age of forty. It occurs in about one per cent of all persons, in five per cent of persons over forty, and in twelve per cent of persons over forty-five years of age; and it is an incidental finding in five to ten per cent of all cases subjected to roentgenological examination of the colon for any cause. The diverticula are of the pulsion type, developing from within outward; and are of the acquired or false variety, lacking the muscular coat. They represent hernial protrusions of the mucous and submucous coats, "herniae mucosae", through weak points in the musculature. Being usually concealed by the subserous fat or by the appendices epiploicae, when dissected out, they appear as bluish black sacculi arranged roughly in two parallel rows. (Diagram I.) The color is distinctive of the false diverticulum, and is dependent on the presence of fecal matter within its lumen. They vary in number from a few to several hundred, forty to fifty being found in the average case; in diameter, from a few millimeters to several centimeters; and in shape, from shallow depressions with wide openings, to flask-like pouches with small mouths, narrow necks, and wide ampullae. The entrance of fecal matter into those with

wide ampullae is easy, and its escape difficult, resulting in fecal stagnation, the formation of concretions, and finally infection. They appear in the colon with increasing frequency from right to left, the maximum number always occurring in the sigmoid and the lower portion

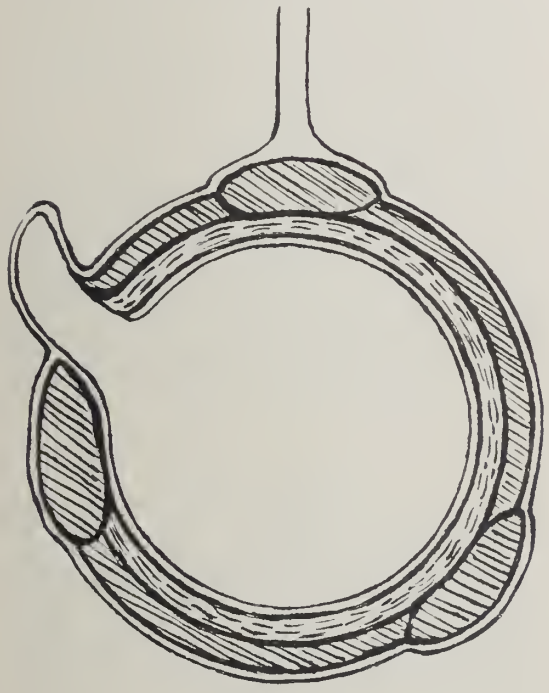


DIAGRAM II.

Diagram to show the common site for a succulus of the large intestine,—between the mesenteric and lateral longitudinal muscular bands. *(Drummond.)*

of the descending colon. They are rarely seen in the rectum, probably because of the strength and completeness of its longitudinal muscular coat, and the intermittent character of the distention to which it is subjected.

"The exact situation of diverticula in relation to the circumference of the bowel is remarkably constant. They appear between the mesocolic and the antimesenteric longitudinal muscle bands, rather closer to the latter than to the former. (Diagram II.) They are definitely related to the blood vessels entering from the mesentery. (Diagrams III and IV.) When numerous in the sigmoid, however, they may not confine themselves strictly to the vessel points, but as a result of the generalized weakening of the musculature, they may crop out promiscuously all over the area between the mesocolic and the antimesenteric longitudinal muscle bands." (Mailer.) They are never found between the leaves of the mesentery, and rarely upon the antimesenteric surface of the bowel.

There is still no unanimity regarding the mode of production of diverticula; but it is probable that, as in the development of typical hernia elsewhere, the protrusion represents the result of the summation of several factors, viz:

a. Insufficient resistance of the retaining wall.

b. Increased pressure from within.

c. The passage of a structure through the retaining wall forming a "locus minoris resistentiae" along which the protrusion makes its course.

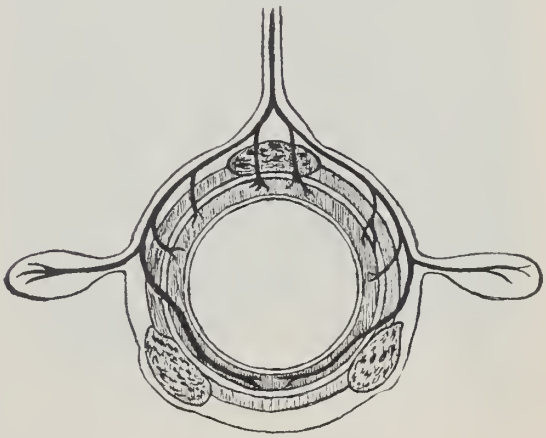


DIAGRAM III.

Diagram to show muscle tissue and blood vessels of the pelvic colon. *(Drummond.)*

In occasional instances congenital insufficiency of non-striated muscle tissue will explain the occurrence of this type of diverticula, associated with similar diverticula in other organs, in young people without debility and without local intestinal disease. Usually, however, the diminished tone of the intestinal musculature is an integral part of a general muscular deterioration occurring naturally in the course of advancing years, or resulting from debilitating diseases and general degenerative changes, in which category obesity must be given prominent mention. While much less importance is attached to this factor than formerly, it must still be regarded as conducive to intestinal atony, representing as it does a vicious combination of lack of exercise, over-

eating, and deposition of fat in and around the walls of the colon.

Intracolic pressure is increased by constipation, the ingestion of excessive amounts of food leaving a large residue, certain intestinal disorders accompanied by excessive fermentation, and by the injudicious use of enemata or high



DIAGRAM IV.

Interior of the pelvic colon laid open through the antimesenteric border, to show the common site of sacculi, which appear at a point where the vessels perforate the muscle tissue, and come to lie under the mucous membrane. *(Drummond.)*

colonic irrigations. The sigmoid is most affected by such increased pressure since, in civilized man at least, it acts as a reservoir for the storage of gas and solid matter until a convenient time for defecation. Increased pressure from within, however, is not alone capable of producing diverticula for they do not occur with especial frequency above an area of long-standing chronic obstruction due to carcinoma or stricture.

Much discussion has centered around the rôle played by various structures in their passage through the wall of the colon. Bland Sutton believed that the appendices epiploicae bore an etiological relationship to the development of diverticula, and he published diagrams in which he demonstrated that the fat of the submucous coat was continuous with that of the epiploic bodies. McGrath disagreed with this view and held that the relationship was one of propinquity only, pointing out that these fatty masses are situated either directly upon or close to the points where the large vessels enter the intestinal wall, since they are the terminations of fat bands extending from the mesentery and covering these vessels. The consensus of most authorities at present holds, with Drummond and Mailer, that diverticula occur with great uniformity at points where the large vessels penetrate the muscular coat; that the orifices thus formed determine the sites of herniation; and that the relationship of the blood vessels of the colon to diverticula is similar to that of the spermatic cord to inguinal hernia.

DIVERTICULITIS

The anatomical peculiarities of many diverticula, by reason of defective drainage, predispose them to secondary pathological changes of an inflammatory character described as "Diverticulitis". Such changes occur in about twelve per cent of cases of diverticulosis. While diverticulosis may affect the entire colon, the occurrence of diverticulitis is, with rare exceptions, limited to the sigmoid and descending colon, probably because of the solidity of the fecal mass in the terminal portion of the colon, which favors the formation of fecal concretions within the lumen of the diverticula. The inflammatory changes are extra-lumenal in relation to the colon, and may be limited to the mucosa of the diverticulum, or to the peridiverticular tissues alone, the mucosa being unaffected. Usually, however, there is present a combination of diverticulitis in association with peridiverticulitis, the latter being markedly predominant in the seyerer cases. It is at present universally agreed that the pathological conditions formerly described as sigmoiditis and perisigmoiditis actually represent phases of diverticulitis, just as typhlitis and perityphlitis are now known to be part of the pathological change occurring in appendicitis.

The factors leading to diverticulitis and peridiverticulitis are:

a. Atrophy of the mucosa of a diverticulum from increasing distention.

b. Ulceration of the mucosa from the perforating action of retained concretions.

c. The passage of bacteria or their toxins into the peridiverticular tissues.

The inflammatory changes occurring in diverticulitis resemble closely those found in appendicitis, with the exception that in diverticulitis the tendency is markedly toward the production of a plastic exudate with the formation of adhesions, while in appendicitis it is distinctly toward perforation. By far the most frequent, the acute catarrhal variety may produce an inflammatory mass along the sigmoid; but it runs a self-limited course without complications and undergoes practically complete resolution. While acute perforation of a diverticulum into the general peritoneal cavity may occur as the result of suppurative or gangrenous diverticulitis, usually, because of the great mobility of the sigmoid and the marked adhesive tendency of the inflammation, the affected area is promptly isolated by adhesion of the sigmoid to neighboring viscera or to the parietal peritoneum, resulting in the restriction of the ensuing peritonitis to the pelvis with the subsequent development of a distinct inflammatory tumor. The mass may involute completely, or it may undergo suppuration. Abscesses thus formed may rupture into the general peritoneal cavity, the colon, or neighboring hollow viscera; or they may burrow through the abdominal wall to appear on the exterior of the body in the left lower quadrant or at some more distant point.

Suppuration frequently leads to the formation of fistulae, either directly or through abscess cavities. The most common variety is the vesico-sigmoidal fistula formed by close adhesion of the sigmoid to the bladder. Other varieties are cutaneous, and entero-, utero-, vagino-, and recto-sigmoidal fistulae. In chronic diverticulitis and peridiverticulitis, while abscesses and fistulae develop, the inflammation more commonly assumes a hyperplastic character, producing great thickening of the wall of the sigmoid and invading the mesentery, where it produces chronic mesenteritis.

The predominating feature of this type of diverticulitis is the tendency to produce chronic intestinal obstruction due to hyperplasia, adhesions, and angulation. "It is surprising, however, when the entire mass is dissected out and the diseased bowel laid open, to find so little obliteration of the lumen of the bowel; and, unlike cases of carcinoma of the sigmoid, the obstruction is rarely complete." (Mayo.)

The relationship between diverticulitis and carcinoma has given rise to much discussion. It was formerly believed that diverticulitis was a frequent predisposing cause of carcinoma of the sigmoid; but, although there have been undoubted instances where carcinoma has developed upon the basis of diverticulitis, it is now practically certain that the relationship is incidental and not etiological, the two conditions having been found associated in less than four per cent of a very large group of cases.

For clinical purposes diverticula may be classified as:

A. Diverticulosis, including that group of cases in which evidence of diverticula is found by roentgenographic examination or at necropsy; and in which, from all available data, the diverticula do not bear any relationship to the patient's complaints.
B. Diverticulitis
    1. Acute
    2. Chronic
    3. Complicated
        a. Abscess formation
            i. Local
            ii. Metastatic due to pylephlebitis.
        b. Fistula
            i. External
            ii. Internal
                a. Vesical
                b. Colonic
                c. Enterocolic, etc
            iii. Multiple
        c. Obstruction
            i. Acute
            ii. Chronic
    4. Associated with carcinoma

SYMPTOMS

Diverticulosis is a symptomless condition, unrecognizable clinically; but it is often discovered accidentally in the course of a roentgeno-

logical examination of the alimentary canal. Diverticulitis and peridiverticulitis, however, present a wide range of symptoms depending upon the type and severity of the inflammation, and the character and location of the complications which may develop. The great majority of cases encountered in private practice are examples of the catarrhal, self-limited, or uncomplicated variety of acute diverticulitis. Such cases occur much more frequently than is generally appreciated; and are often unrecnized, being mistaken for colitis, intestinal indigestion, or other abdominal disorders.

The patient, usually a male past forty, of sedentary habits, stocky build and rotund figure, gives a history of one or more previous similar attacks, and now complains of more or less severe colicky pain in the lower left quadrant of the abdomen accompanied by nausea, increasing difficulty in evacuation of the bowel, and irritation of the bladder. One notes the presence of fever, distention of the abdomen, and tenderness in the hypogastric and left iliac region; and, in a short time, one may, perhaps, palpate a tender mass along the course of the sigmoid. Such a mass is usually best felt by combined rectal and abdominal palpation.

The symptoms persist for a few days or weeks; but improvement is indicated by the diminution of the pain and tenderness, the easier expulsion of gas and feces, the subsidence of the fever, and the gradual disappearance of the mass. The entire episode covers a period of about two weeks, and subsides spontaneously, leaving practically no remaining symptoms except dull pain and rather obstinate constipation of the "spastic" type.

In suppurative or gangrenous diverticulitis the clinical picture is often that of acute generalized peritonitis, the origin of which may be in doubt unless the history of the onset furnishes a clue, or unless one is aware of the existence of diverticulosis in the patient under observation.

The symptoms in chronic diverticulitis are, chiefly, continued dull pain in the lower portion of the abdomen especially on the left side, increasing constipation, and the development of a tumor along the course of the sigmoid. The passage of blood or mucus in the stools is relatively rare, having been noted in only seven per cent of a large series of cases, and in many of these it was due to hemorrhoids or other rectal diseases rather than to diverticulitis. The symptoms occurring in complicated cases depend upon the location and character of the complications. They range from the passage of gas and feces with the urine to persistent vomiting due to obstruction of the jejunum, consequent upon adhesions and angulation.

DIAGNOSIS

With the exception of roentgenological examination, which is of paramount importance, diagnostic aids render only slight assistance in the recognition of diverticulitis. There are no characteristic changes in the blood or feces in this condition, although a marked leucocytosis may be found in acute diverticulitis. The development of a considerable degree of secondary anaemia would point to carcinoma in doubtful cases. A blood Wassermann test should be routinely made in all cases.

Sigmoidoscopic examination is of little value because of the extra-lumenal location of the lesions; and only occasionally may the mouths of diverticula be visualized through the instrument. It may be useful in the differential diagnosis of carcinoma of the sigmoid, by revealing the presence of an intramural ulcerating tumor, indicating the existence of malignancy; but its use is not entirely safe owing to the danger of perforating the sigmoid when it is involved in a fixed and friable mass.

In all cases of diverticulitis in which blood has appeared in the stools, a *proctoscopic* examination should be made to determine its possible origin in hemorrhoids or other lower rectal lesions. The *cystoscope* may be of service in locating exactly the vesical opening of a vesico-sigmoidal fistula, but the existence of a fistula is much more dramatically demonstrated by the passage of gas and feces with the urine.

X-RAY FINDINGS

Roentgenology furnishes the only positive diagnostic evidence of diverticulosis and diverticulitis with its complications. In diverticulosis roentgenograms show the diverticula appearing as rounded knob-like protuberances from

the sides of the colon when it is filled with barium; and, following evacuation, isolated shadows may appear along the course of the colon, indicating the retention of barium within the ampullae of the diverticula, where it may remain for many weeks. The individual diverticula may be best demonstrated by stereoscopic films taken following evacuation of the barium enema and the subsequent inflation of the colon with air.

(See figure 1, A and B, on page 31, illustrating the article by Dr. Marquis.)

In diverticulitis the roentgenological findings resemble those occurring in inflammatory lesions of other hollow viscera, viz: hypermotility and spasm. The hypermotility may vary in degree from a sharply serrated appearance of the haustra in a narrowed segment of bowel, described as "Palisading" or "Steepling", to almost complete occlusion of the lumen.

The filling defect almost universally encountered may be *false*, resulting from spastic contraction of the affected segment which may be sufficient to produce complete occlusion; or *true*, resulting from the encroachment of pericolic inflammatory exudate upon the lumen of the bowel. Antispasmodic drugs in full doses may modify the appearance of the false type, but will have no effect upon the true, except that of relieving concomitant spasm. Roentgenograms may also demonstrate the existence of sinuses and fistulae of various kinds connected with areas of diverticulitis.

Although a positive diagnosis of diverticulitis can be made only by roentgenological examination of the colon, it is nevertheless surprising to find how frequently a provisional diagnosis is subsequently verified. By careful consideration of the history and the clinical findings, one may recognize a typical case of acute diverticulitis as easily and confidently as the usual case of appendicitis. One need only think of acute diverticulitis as *acute appendicitis occurring on the left side*, and he will have an accurate idea of the clinical picture usually observed in diverticulitis.

In the suppurative and gangrenous types of diverticulitis with general peritonitis, the diagnosis may be impossible except by operation, unless the history of onset with pain in the left lower quadrant of the abdomen gives one a hint as to the cause of the peritonitis. No exploratory laparotomy for general peritonitis of undetermined origin is complete without a thorough inspection and palpation of the sigmoid in the search for an acute perforation of a diverticulum. Diverticulitis must be given consideration in all cases of inflammatory masses occurring in the pelvis of older subjects; in all abscesses, fistulae, and sinuses in which communication with the lower portion of the colon is even remotely possible; and in all cases of acute or chronic obstruction of the sigmoid.

DISTINCTION FROM CARCINOMA

Although diverticulitis may require differentiation from a number of other diseases, it most often must be distinguished from carcinoma of the sigmoid. While the distinction is still occasionally impossible except by microscopic examination of an excised specimen, as a rule a careful review of the history, physical findings, and roentgenograms will enable one to differentiate the two conditions with reasonable certainty.

The onset of carcinoma is insidious, usually painless, and aside from the passage of blood gives no local symptoms except constipation increasing to the point of complete obstruction. In diverticulitis there is frequently a history of one or more attacks suggestive of acute diverticulitis, and there is apt to be much more pain and local tenderness on palpation.

The repeated passage of blood and mucus with the stools is a strong point in favor of carcinoma, as bleeding occurs in 47 per cent of cases of carcinoma and in only seven per cent of cases of diverticulitis. One may also be able to view an intramural ulcerating carcinomatous mass through the sigmoidoscope.

The roentgenoscope reveals hypermotility and spasm in diverticulitis in contrast to the fixed immobility of carcinoma. The roentgenograms in diverticulitis show the involvement of a large segment of the sigmoid, with evidence of spasm above or below the filling defect and the presence of isolated diverticula higher in the colon. In carcinoma the filling defect area is usually short, with sharply irregular con-

tours, without associated spasm and without evidence of diverticula.

TREATMENT OF DIVERTICULOSIS

The treatment of diverticulosis is prophylactic, calling for care in the diet, relief from constipation, and hygienic measures directed toward improvement in the general health. The diet should be of a bland character, leaving comparatively little residue. The constipation is best managed by small doses of mineral oil taken four or five times a day. Given in this manner, the fecal mass is softened and oil leakage is less troublesome. Enemata should be used with caution, and colon irrigation should be avoided altogether. The administration of barium in fairly large amounts, by filling the diverticula with a non-irritating substance, may help to ward off attacks of diverticulitis.

TREATMENT OF DIVERTICULITIS

The treatment of uncomplicated acute and chronic diverticulitis should be strictly medical. In acute cases, rest in bed, together with the administration of antispasmodic drugs, particularly belladonna in full doses, should be added to the measures noted above.

The operative treatment of diverticulitis should be limited to those cases presenting complications. This group comprises not more than ten per cent of the total number, and includes those with (1) acute perforation, (2) abscess, (3) fistula of any type, (4) inflammatory obstruction, and (5) malignancy.

The ideal management of acute perforation is removal of the diseased diverticulum, with closure and inversion of the base, coverage of the area by neighboring epiploic bodies, and drainage of the pelvis. Fortunately these cases are rare, as the mortality is very high due to the contamination of the peritoneal cavity by gross fecal particles.

Abscesses should be exposed by incisions placed over the point where they are most accessible. If firmly adherent to the parietal peritoneum, they may be opened and drained at once. If not so walled off, the area should be isolated from the general peritoneal cavity by gauze packing, and the abscess opened three or four days later.

Fistulous and obstructive types of diverticulitis usually require for their cure *resection of the sigmoid,* which, with rare exceptions, should be undertaken as a graded procedure in three stages. Owing to infection and inflammatory hyperplasia involving the mesentery and other adjacent structures, primary resection is attended by a high mortality rate, while immediate closure of fistulous openings is almost surely doomed to failure.

Prolonged preliminary exclusion of the affected segment of the colon by colostomy allows time for the inflammatory process to subside, the exudate to be absorbed, the fistulous openings to contract and perhaps close, and finally for the cleansing and partial sterilization of the involved bowel by through and through irrigation. The site of election for the colostomy, which should be of the spur type, is in the transverse colon to the left of the midline. While it is being made, one may take advantage of the opportunity to mobilize the splenic flexure of the colon by division of its ligamentous attachments. This step will greatly facilitate the subsequent anastomosis following resection of the sigmoid. After the lapse of not less than four months the resection and the closure of fistulae may be accomplished with comparative ease and safety in a relatively aseptic field with tissues in nearly normal condition. The operation of choice is resection, with end to end anastomosis, but occasionally the anterior tube resection of Balfour or the graded Mickulicz or Rankin resection may better serve the individual case. Usually the colostomy is closed about four weeks later, when firm union of the anastomosis is assured. In some cases improvement following colostomy is so great that resection becomes unnecessary, and the colostomy may be closed without other operative treatment, it being first ascertained that no cicatricial obstruction exists in the sigmoid area.

CONCLUSIONS

In conclusion, emphasis should be placed upon:

1. The frequency of diverticulosis.
2. The frequency and ease of recognition of the self-limited type of acute diverticulitis.

THE ROENTGEN DIAGNOSIS OF DIVERTICULOSIS AND DIVERTICULITIS OF THE COLON

By C. F. Baker, M.D., and W. J. Marquis, M.D., Newark, N. J.

Read before the Radiological Section at the Annual Meeting of The Medical Society of New Jersey on June 4, 1936, at Atlantic City

Abstract.—According to statistics, diverticula are found in over five per cent of all individuals over forty, and the condition is said to be more frequent in men than women. We found sixty-four cases in a series of 481 consecutive colon examinations, and of these forty were women and twenty-four were men.

It is commonly accepted that diverticula of the colon do not have any muscular coats in the walls of the sacs. We have noted on fluoroscopic examination an apparent contraction of the sac, indicating that there may be some muscle tissue in the walls of some diverticula.

We have found no one method of roentgen examination superior to others, and depend upon a combination of all.

The diagnosis of simple diverticulosis is usually easy and definite. Diverticulitis must often be made on evidence of spasm of the sigmoid, without direct demonstration of diverticula, in individuals presenting clinical findings which are not inconsistent with such a diagnosis.

The differential diagnosis between carcinoma and diverticulitis may be very difficult. Six cases are presented, arranged in pairs so grouped that one of each pair was carcinoma and the other, diverticulitis; and one of each group had features common to both diseases.

Our interest in a study of this subject was aroused by observing several patients during the past year in which carcinoma was found, either in the presence of an accompanying diverticulosis, or in which diverticulitis complicated the diagnosis and rendered differentiation either difficult or impossible. There were also several cases showing persistent obstruction without any roentgen evidence of diverticula in which operation revealed the presence of diverticulitis.

W. J. Mayo states that diverticula of the colon were first described by Cruveilhier in 1849. Carman and Enfield give Abbe credit for first describing a case examined by the x-ray, the examination being made by LeWald and reported in 1915. Enfield states that Carman was the first to report a series of cases examined by the x-ray and was the first to formulate a scheme for the recognition and differential diagnosis of diverticulosis.

It is not within the scope of this paper to give a detailed account of the clinical findings. Most of the cases were individuals in which the diverticula were found incidently during the course of a gastro-intestinal examination. In those cases which showed active inflammation of the diverticula, the symptoms were those of a more or less acute process in the left lower quadrant of the abdomen, usually in a patient over forty years of age.

AGE AND SEX INCIDENCE

Most articles written about diverticula of the colon state that the patient is usually over forty. We had one patient aged twenty-eight years, but the majority of the individuals were over sixty years.

The incidence as given in the literature varies, but W. J. Mayo states that the condition is likely to be found in a little over five per cent of all persons over forty years of age. We found sixty-four cases in a series of 481 colon examinations. The experience of one of us (W. J. M.) indicates that the incidence will vary, depending upon the section of the country in which the individual lives. Thus it would appear that fewer cases occur along the Gulf Coast than in the Middle Western and Northeastern sections of the United States.

Our series is unusual in that we found the condition more frequently in women than in men. Thus, at one hospital we found nineteen women to twelve men having roentgen evidence of diverticula. At another the ratio was twenty-one women to twelve men. This agrees with Wilkinson, who found 63 per cent of 117 cases to be in women and 37 per cent

in men. We have found no apparent explanation for this difference and most writers state that the condition is more likely to occur in men than women at a ratio of two or three to one. It is possible that if we had a larger series, the ratio of women to men affected would be changed.

LOCATION

Diverticula may be grouped as true or false, acquired or congenital. Enfield states that from a clinical standpoint, they are always false and acquired; that is, they involve only the mucosa and the serosa, the mucous membrane being herniated through an opening in the muscular coat. Kohler believes that these herniations occur mostly at places where blood vessels perforate the walls. Enfield found that the herniations usually took place on either the mesenteric or anti-mesenteric border, a fact which renders their recognition on roentgen examination the more likely. Schaaf quotes Mailer as follows:

"The exact situation of diverticula in relation to the circumference of the bowel is remarkably constant. They appear between the mesocolic and the antimesenteric longitudenal muscle bands, rather closer to the latter than the former. They are definitely related to the blood vessels entering from the mesentery. When numerous in the sigmoid, however, they may not confine themselves strictly to the vessel points, but as a result of the generalized weakening of the musculature, they may crop out promiscuously all over the area between the mesocolic and the antimesenteric longitudinal muscle bands."

METHOD OF EXAMINATION

In the roentgen examination by barium enema, the small hernial sacs appear as small rounded projections which extend outside the lumen of the intestine. If there is any active inflammation present of the walls of any of the diverticula, there will be a certain amount of spasm of the circular muscles of the wall of the intestine, the degree varying with the amount of inflammation present. The lumen of the intestine will then be somewhat narrowed and have a serrated appearance described by some authors as palisading of the haustral markings. Fig. 1 a illustrates such a case. Only a portion of the sigmoid is shown in the illustration, and on careful examination one can make out the rounded projections of the hernial sacs filled with barium. One can also note the irregular outline of the lumen producing the serrated appearance or the so-called palisading of the haustra.

In a roentgenogram made twenty-four hours after taking a barium solution by mouth, the sacs may retain the opaque medium and will appear as small isolated, rounded shadows lying along the course of the colon. Fig. 1 b is a portion of the sigmoid of the same patient as Fig. 1 a but the roentgenogram was made twenty-four hours after taking a barium solution by mouth. One can see many small isolated shadows following the course of the bowel.

We have not found any one method of examination superior to others. Case No. 2 shows the diverticula to be best demonstrated in the roentgenogram made after evacuation of the barium enema. (Fig. 2 a, b.) In case No. 3 the twenty-four-hour roentgenogram best visualized the diverticula (Fig. 3 a and b); and case No. 4 illustrates the advantage of the barium enema in certain instances as the diverticula were not well shown in the twenty-four-hour roentgenogram and yet clearly demonstrated by barium enema (Fig. 4 a and b). We have found that in our experience a combination of these methods and a fluoroscopic observation at the time the barium enema is given will give the greatest percentage of positive findings. One must make roentgenograms with the patient in various positions and also make a very careful fluoroscopic examination, since the diverticulum may be masked by the barium in overlying portions of the colon or sigmoid.

We have not used stereoscopic roentgenograms nor air inflation after the evacuation of the barium enema excepting in rare instances.

INVOLVEMENT OF MUSCULAR COAT

Most students of diverticula believe there is no muscular coat in the wall of the diverticulum; and that the strong muscular contractions of the intestinal wall raises intra-lumenal pressure, which may force fecal contents into a small diverticulum and cause enlargement, or may be a factor in the formation of a sac in a weak point in the intestinal wall. This



FIG. 1 A

Fig. A represents the typical appearance of a roentgenogram made after injection of a barium enema in an individual in which many diverticula are present, and in which there is a moderate amount of inflammatory reaction. Note the large spherical masses protruding outwards from the lumen of the bowel, and the irregular hazy outline of sigmoid at this point.



FIG. 1 B

Fig. B represents a portion of a roentgenogram of the same individual as 1 A made 24 hours after taking barium mixture by mouth, and illustrates the spherical masses of barium that have been retained in the pouch-like formations. In this particular case, there were many diverticula, as nearly every barium shadow represents a diverticulum.



FIG. 2 A



FIG. 2 B

The barium enema (A) does not visualize the diverticula clearly; but in the roentgenogram made after evacuation of the barium (B), they are more clearly shown.

may be true in regard to the formation of the large, well-formed sacs in which there is no inflammatory reaction. Enfield, however, states that he has reëxamined individual cases at intervals of two, three and four years and has not been able to detect a change in the size of the diverticula which had formed previously or to note that any new diverticula had formed during the intervals. We have never observed the enlargement of a small diverticulum into one of greater size, nor have we noted an addition to the original number found. It is true that at times one will be able to demonstrate more diverticula than at another because of technical conditions.

We have noted that in those cases in which there was marked spasm of the colon, seldom are well-developed diverticula present. Also that very often careful observation on fluoroscopic examination will show a very small extraluminal shadow which appears momentarily and then disappears, independently at times of the contraction of the intestine. This would indicate that in those cases there probably was a muscular coat in the walls of the small sac. Cole has found that sections of some of these areas which have been resected show herniation of the mucous membrane between the muscle coats producing a pouch or diverticulum between the muscle layers. He further states that this may account for the serrated appearance frequently seen in the sigmoid which has been referred to as the "pre-diverticula stage". This might account for the apparent contraction of the sac, thus emptying its contents except that these shadows sometimes project so far beyond the lumen that they would appear to extend beyond the thickness of the wall of the intestine.

In those cases showing marked spasm of the sigmoid, Cole states that the absence of any filled diverticula does not mean that the process is not essentially a diverticulitis, since an involved diverticulum or diverticula may be occluded by the inflammatory process or the diverticulum may not yet be sub-serous. The roentgen diagnosis of diverticulitis may therefore be made in those cases of persistent marked localized spasm, usually of the sigmoid, in which no other lesion is apparent (Fig. 5). The diagnosis may be verified by an examination made after several days of rest, the patient taking large doses of an antispasmodic, daily doses of mineral oil, and a bland non-residue-forming diet. Occasionally the reverse is found; that is, diverticula may be noted in a routine examination of the gastro-intestinal tract and then develop a diverticulitis at a later date (Fig. 6 a and b).

DIFFERENTIAL DIAGNOSIS

In simple diverticulitis one rarely has difficulty in making a differential diagnosis. Occasionally in those cases in which only one or two diverticula are found, a phlebolith, or a ureteral or renal stone may be confusing. A correct diagnosis can usually be easily arrived at by having sufficient roentgenograms made with the patient in different positions so as to demonstrate the confusing shadows in their true location.

In the twenty-four-hour film, barium residues in the deep haustra may very closely resemble multiple diverticula. A barium enema given after thorough preparation nearly always distinguishes the true condition.

In diverticulitis, particularly in those cases in which no diverticula can be demonstrated, the diagnosis may be impossible on a single examination. Repeated examinations after antispasmodic administration may be needed in order to demonstrate the diverticula. A tentative diagnosis, however, can be made because of the marked spasm, localized tenderness in the sigmoid and descending colon occurring in a patient over forty.

In those patients in which diverticula can be demonstrated, one is often perplexed as to whether or not carcinoma may be present. As Cole says, "The paramount question is, 'Is it or is it not a malignant lesion?'" and, "The line of demarcation between an inflammatory area and the normal is not as sharp and well defined as between a malignant area and normal adjacent tissue."

CARCINOMA

Enfield states that in uncomplicated cancer and in uncomplicated diverticulitis no confusion is likely to arise; but that difficulty arises



FIG. 3 A



FIG. 3 B (new)

Many diverticula are demonstrated in the 24-hour roentgenogram (A); but none are shown in the roentgenogram made after injection of a barium enema (B).

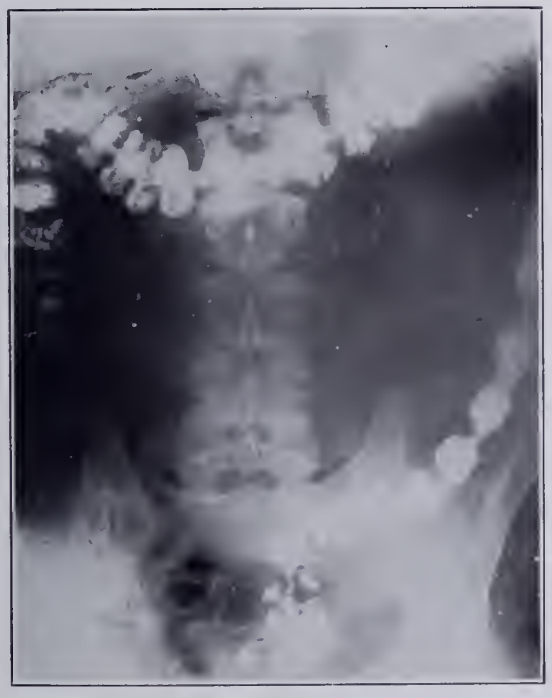


FIG. 4 A



FIG. 4 B

In this case the 24-hour roentgenogram (A) does not clearly show any diverticula; whereas the roentgenogram made after injection of a barium enema visualizes at least one (B).



FIG. 5 A



FIG. 5 B

The 24-hour roentgenogram is very suggestive of diverticula (A). The barium enema showed marked spasm in the sigmoid but no definite diverticula (B).



FIG. 6 A



FIG. 6 B

The roentgenogram (A) was made during a routine gastro-intestinal examination. Several small diverticula are shown but no spasm. Several months later clinical symptoms developed which were suggestive of diverticulitis; and a barium enema showed marked spasm in the sigmoid, but only a few diverticula (B).

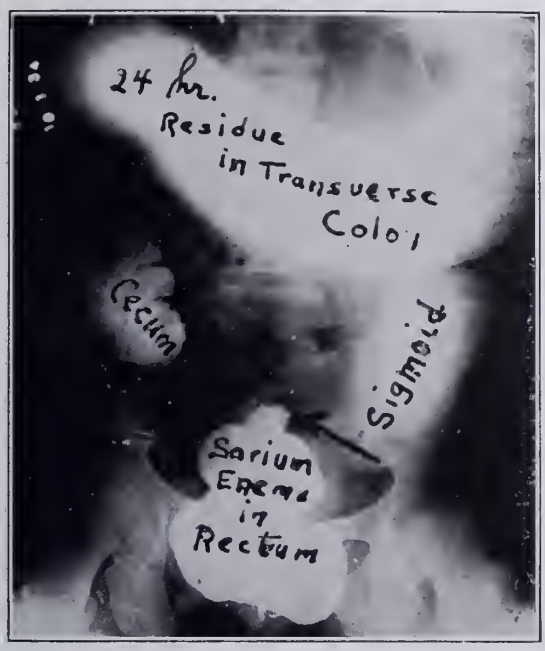


FIG. 7 A (new)



FIG. 7 B

Figs. 7 A and B are roentgenograms made on two patients after attempting to inject a barium enema in each. These showed complete obstruction in both patients. The barium in the proximal colon of the first patient in A was due to barium given by mouth previous to the enema. A small diverticulum is noted in the roentgenogram (B) of the second patient.



FIG. 8 A



FIG. 8 B

Roentgenograms made 24 hours after taking barium by mouth showed dilatation of the proximal colon in each patient. No diverticula or spasm are shown. At operation, diverticulitis was found in the first patient, Fig. 7 A and 8 A; whereas carcinoma was found in the second patient, Fig. 7 B and 8 B.

when one is trying to determine whether narrowing in a colon showing diverticulosis is due to the benign process alone, or to malignancy. He further states that in his opinion, it is in the early case quite impossible to determine this from the roentgen ray examination alone.

This has also been our experience,—that is, given a case in which several diverticula are present plus a filling defect, is the filling defect due to an inflammatory process about some of the diverticula which are not demonstrated? or is it a carcinoma developing in an individual already having diverticula?

ILLUSTRATIVE CASES

The following two cases illustrate this point. Both cases showed practically complete obstruction to a barium enema. (Fig. 7 a and b.) In both there was marked dilatation of the colon proximal to the lesion, and yet there is no characteristic spasm of the sigmoid. (Fig. 8 a and b.) The only diverticulum noted was the one distal to the lesion and seen only in the barium enema. (Fig. 7 b.) The first case A was diverticulitis and the second, B, carcinoma. It may be said that there should be no confusion between these two cases since the second shows a lesion somewhat proximal to the usual site of diverticulitis. There is also an abrupt ending to the normal intestine, and the diverticulum is just an incidental finding. This is conceded; but can one reasonably exclude diverticulitis from the diagnosis? In the first case shown in Fig. 7 a, and 8 a, can one exclude carcinoma?

We also observed four additional cases, two of which were carcinoma and two were diverticulitis. These cases could be grouped in pairs, as the two preceding cases, so that each one of the pairs presented roentgen findings similar to the other and yet the one was a case of carcinoma and the other diverticulitis. Space does not permit the roentgenograms of these cases to be illustrated.

In the one pair of this group, spasm with a persistent filling defect was found in each case. In one patient the defect was due to carcinoma; in the other, to an abscess between the leaves of the mesentery pressing on the wall of the intestine and secondary to a diverticulitis.

Cases No. 5 and 6 of this group did not show quite as similar features to each other as the preceding cases; however, there were some resemblances between the two. At the time of the first examination the roentgen findings were not similar, since the first case presented evidences of a filling defect with several shadows suggestive of diverticula in the sigmoid, whereas the second showed only a filling defect without spasm near the junction of the descending colon and sigmoid. A reexamination of the first case eight days later showed complete obstruction. This would tend to make one believe that there was more or less irritation or spasm present which could be due to diverticulitis. Since the defect as shown in the first examination was rather irregular in outline, and there were several shadows suggestive of diverticula, one might readily conclude that the findings were indicative of a diverticulitis. The patient died soon after this examination with a final diagnosis of carcinoma of the sigmoid. No mention of diveritculitis was made on the autopsy record.

A reëxamination of the second case showed at this time about the same degree of spasm of the sigmoid distal to the defect that was present in the first case in the first examination, but the filling defect was just as marked and was very similar to that found in the first examination. This case was excised, but on microscopic examination of the tissue no malignancy was found. In neither case was it possible to definitely identify any diverticula at the second examination.

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THE DIAGNOSIS OF DUODENAL ULCER BY AIMED COMPRESSION SERIAL ROENTGEN TECHNIC

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In 1925 H. H. Berg [1] wrote as follows: "Still today, despite the work of Holzknecht, Haudek, Case, Cole, Akerlund, and Barclay, the majority of Roentgen examiners of the alimentary tract prefer to use the symptom complex of the *indirect* signs of diagnosing duodenal ulcer, and do not take notice of the *direct* method which seems to be the privilege of particularly trained explorators."

In 1926 there appeared Berg's [2] monumental study of the x-ray diagnosis of duodenal ulcer. Here he presented a complete review of all the literature on the subject. He described the technical details of his device for rapid change from fluoroscopy to x-ray, and the manner of taking four serial compression films on one 18 x 24 cm. roentgen plate.

He discussed the ulcer niche and the duodenal mucous membrane changes in ulcer, and emphasized the importance of screening and filming in various positions in order to show the niche detail. Above all he stressed the necessity for compression of the duodenum in order to clearly demonstrate changes in the mucous membrane.

In 1930 Boman,[3] in the first *American* article on compression technic in gastro-duodenal roentgen diagnosis, stated: "The compression technic of Akerlund and Berg is comparatively unknown in this country."

In 1931 Akerlund,[4] in summarizing his work in English, stated that the *direct* study of duodenal ulcer had nearly everywhere replaced the older indirect method by which the diagnosis of duodenal ulcer was based upon certain functional or secondary signs. This statement *may* have been true abroad, but it was certainly *not*, and still *is* not, the case in the United States.

Articles by Potter,[5] Geyman,[6] Dresser and Scholz,[7] Gabor,[8] Stewart and Illick,[9] Clark and Geyman,[10] and Bell [11] have further demonstrated the value of aimed serial compression roentgenography, but despite these numerous contributions the use of this method has not been popular in the United States.

It is beyond the scope of this paper to go into all the reasons for this lack of progress in the diagnosis of duodenal lesions. However, the reluctance on the part of manufacturers of x-ray apparatus to produce a practical aimed compression serial device at a reasonable price is a decided factor.

Secondly, the many low-priced x-ray units which have been sold as capable of taking all types of films have neither the speed nor the penetration for taking duodenal films properly, and do not lend themselves to the adoption of a device for rapid change-over from fluoroscopy to radiography.

Thirdly, having all radiographs taken by technicians, which is common practice in many of our large hospitals, has mitigated against this more accurate method of ulcer diagnosis, which demands the presence of a qualified roentgenographic physician.

Lastly, this procedure is time consuming. Akerlund [4] estimated that a trained observer required from fifteen to thirty minutes with every patient. The physician familiarizing himself with this technic will require at least forty-five minutes for each duodenal examination. I have, with the assistance of my technician, been able to cut my time for complete esophageal stomach and duodenal examinations to thirty minutes, including the taking of about two upright, four prone, and a dozen or more aimed compression films of the cap.

Aimed Compression Serial Roentgenograms

Despite these difficulties, aimed compression serial roentgenography is here to stay. There has been a paucity of literature on this subject

in the general medical journals usually subscribed to by gastro-enterologists and internists. It is with the hope of being able to familiarize my hearers with this very valuable diagnostic procedure that I present this paper.

In the description of technic and findings I shall use freely the works of some of the aforementioned authors.

Though Barclay [12] as early as 1910 described a flêche of the duodenal bulb as an indication of duodenal ulcer and in 1912 Haudek [13] discovered the importance of the niche and cap distortion as diagnostic aids, it was not until the work of Berg and Akerlund made technically possible the demonstration of these defects that their significance could be fully estimated.

Gregory Cole [14] first recognized the importance of serial duodenal roentgenography, and in 1913 had invented a device for taking aimed serial films of the duodenum. However, he erred when he wrote: "If one radiograph out of fifty shows a perfectly symmetrical cap and a normal pyloric sphincter, a negative diagnosis of post pyloric ulcer is justified." Nevertheless, his insistance on serial films and the taking of many exposures was the lead for the devices of Berg and Akerlund. Holzknecht had studied the duodenal mucosa fluoroscopically. Berg and Akerlund combined the serialography of Cole and the idea of duodenal compression of Holzknecht so as to give us a method for fluoroscoping the duodenum under compression, and to instantaneously enable us to take an x-ray film of what we were seeing at whatever angle and pressure we desired.

I shall now mention some of the devices in use for rapid change-over from fluoroscopy to roentgenography. First came the original device of Berg.[2] This enabled the operator by a single movement of the hand during fluoroscopy to catch on a film precisely that defect he was viewing on the screen, in its optimum position and impregnated with an optimum amount of barium. It is the principle involved in whole, or in part, in all subsequent devices.

Akerlund, Presser, Boman, Potter, Bell, Dresser, and others produced modifications, one of which I have been using pending the installation of a new aimed compression serialograph.

The latest device approaches the ideal in compression serialography. It is interchangeable with a 12 x 16 fluoroscopic screen. It is counterbalanced, and when used with a tilt table will operate properly at any angle from Trendelenberg to vertical. It is so arranged that a lead shielded 8 x 10 cassette lies in a device next to the fluoroscopic screen during fluoroscopy. It is so contrived that four films can be taken in rapid succession, and it is possible to do fluoroscopic examinations between exposures.

METHOD OF TAKING

The entire unit moves universally with the x-ray tube, as does a fluoroscopic screen. To obtain pressure, an automatic lock holds the serialograph in any position to which it is advanced toward the patient. This lock retains any desired pressure. A suitable compression cone is provided.

The shifting of the cassette from its protected position to the exposure position is achieved by moving a handle. At completion of this movement, lifting the handle provides the radiographic exposure.

The electric circuit of the x-ray machine is arranged so that fluoroscopic exposure is made by means of the foot switch, and radiographic exposure by means of the handle controlling the cassette. It is impossible to run the unit at radiographic setting unless the film is in position to take a picture; and impossible to run the machine at fluoroscopic setting unless the cassette is protected.

The entire control for shifting from fluoroscopy to radiography settings is maintained in the handle controlling the cassette. Moving the control handle to move the cassette into position and back again automatically rotates the cassette so that a new part of the film is presented for exposure at each operation.

In order to get duodenal films to yield the maximum of information, every exposure must be made under direct fluoroscopic control in different positions, and with simultaneous palpation, displacement, and compression. This method renders the detection of an ulcer an

exciting and pleasurable procedure, and will be a source of deep satisfaction as the operator acquires the necessary technical skill.

For the demonstration of the duodenal mucosa, I find a simple mixture of barium sulphate and water, well thinned, as good as any proprietary product now on the market. This is in agreement with Akerlund.

Our usual antero-posterior films of the duodenum present silhouettes which outline the lateral walls of the cap. Since most ulcers occur on the anterior and posterior walls, it is essential that the cap be viewed in the right and left anterior oblique positions. The right anterior oblique gives a good view of the anterior wall and the descending duodenum; and the left anterior oblique shows the posterior duodenal wall to advantage.

As demonstrated by Ratkoczi,[15] by using the left anterior oblique position we clear the spine and liver from the path of the rays, and get a good silhouette of the posterior wall of the duodenum. (Fig. 1.)

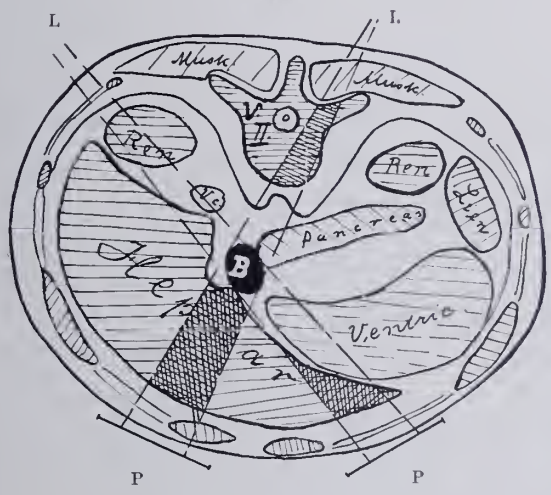


FIG. 1

Cross-section of abdomen at level of duodenum, showing path of rays in oblique positions. Note how the dense structures of spine and liver are avoided in left anterior oblique position.
L, Position of the x-ray tube.
P, The photographic plate or fluoroscope.
B, Duodenal bulb.

FOLDS OF MUCOSA

Figure 2 demonstrates the normal folds of the duodenal mucosa on proper compression (natural size).

With sufficient compression we can often demonstrate a niche on the anterior or posterior wall in the antero-posterior position by displacing all barium except that which is caught in the ulcer excavation. Such ulcers are frequently not detected on the usual type film taken in the antero-posterior position.

NICHE FORMATION

I shall now discuss the direct signs of duodenal ulcer.

The first of these is niche formation. It is erroneous to believe that niche is a rarity in duodenal ulcer. Buckstein[16] in 1930 found niche present in only 29 per cent of his cases; but Akerlund with aimed compression technic was able to demonstrate a niche in 75 per cent of cases. (Fig. 3.)

The second direct sign is a transverse encroachment on the lumen of the bulb resulting in an indrawing or pursing up of the bulbar shadow. (Fig. 4.) These defects are due to local contractions in the muscular coat of the bulb, and are often more apparent than the niche itself. They may be due to scar formation or paraduodenal adhesions. It is often impossible to determine whether the defect is organic or functional. Such a defect may extend into the pyloric muscle ring.

The third sign is a shortening in the length of the bulb, resulting in a flattening of the bulb. (Fig. 5.) This retraction occurs in that longitudinal plane which passes through the ulcer, and is often unilateral. Since ulcers are more common on the lesser curvature, these retractions are more common on that side of the bulb.

The fourth sign is sacular dilatation, or the formation of diverticula. (Fig. 6.) These are caused by the coaction of shrinking cicatricial bands in the region of the ulcer, and pulsion by food on the wall next to it. The niche is always demonstrated on the side of the diverticulum. These diverticula frequently occur in pairs, one on each side of an ulcer. They may diminish or disappear on compression in contrast to the niche which stands out more clearly. They are not to be confused with true congenital diverticula which do not occur in the bulb.



1 2 3

FIG. 2.

Normal duodenal bulb under various degrees of compression. 1, Slight; 2, moderate, 3, hard.

ANNULAR RIDGE OR CORONA

The fifth sign of Akerlund is that of annular ridge or corona; and star formation. (Fig 7 c.) The annular ridge appears as a concave filling defect partially surrounding a niche. It is caused by local thickening and swelling of the mucosa surrounding the niche excavation. Star formation is the result of drawn folds of mucous membrane radiating from the central niche. These radiations are produced by the shrinking of cicatricial bands, and are often seen after an ulcer has healed.

No positive opinion as to the existence of ulcer should be given unless one or more of these direct signs are present. If these signs are absent, at all angles and under varying

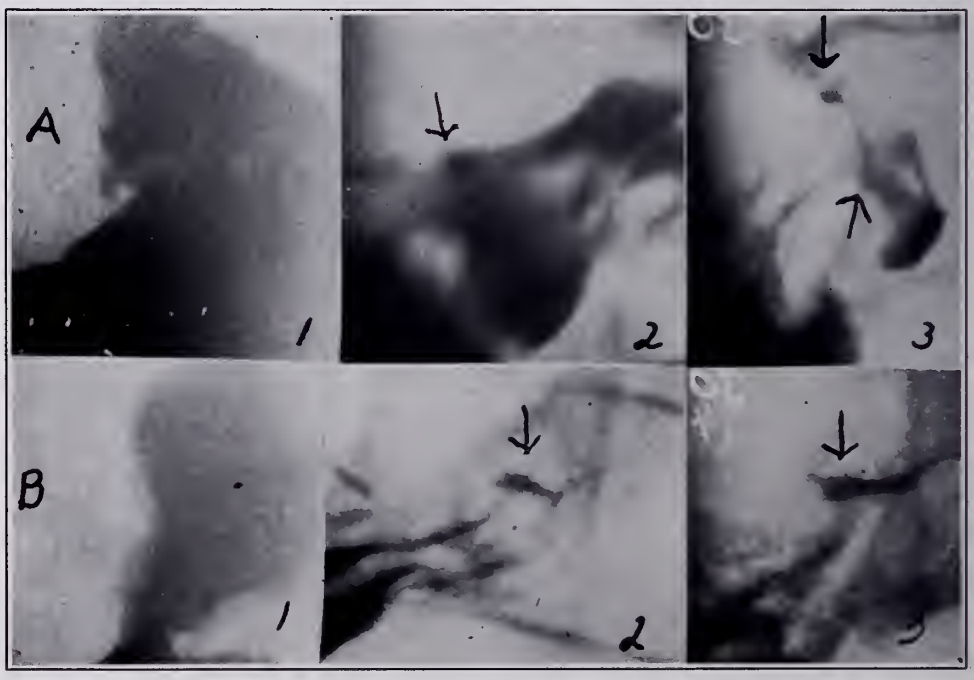


FIG. 3

A—1, Cap without compression; 2, with moderate compression showing a niche; 3, with strong compression, showing two ulcer niches.

B—1, Cap without compression; 2 & 3, with compression, showing niche.



FIG. 4
Showing indrawing or pursing-up of the bulbar shadow.

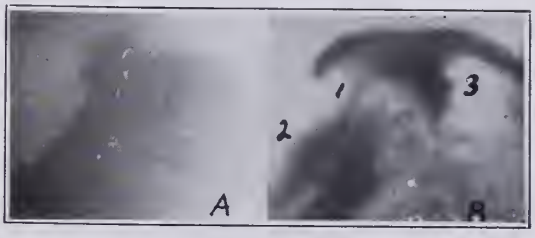


FIG. 5

A, Usual antero-posterior view without compression. B, With proper rotation and compression, showing flattening of the bulb. 1, Pylorus; 2, stomach; 3, cap.

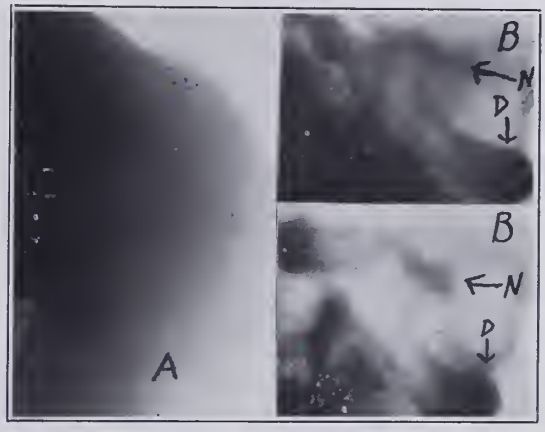


FIG. 6

A, Without compression; B, showing niche (N), and false diverticulum (D), on compression.

degrees of pressure, then only are we justified in rendering a negative opinion.

Not only is aimed compression roentgenography of value in the diagnosis of duodenal ulcer, but in many other lesions of the gastro-intestinal tract.

DUODENAL DIVERTICULA

Duodenal diverticula can be shown to best advantage by proper compression and rotation. (Fig. 8.)

We can also demonstrate the method of healing in gastric ulcers by this device. As originally described by Cole,[17] a benign gastric ulcer heals by the formation of an annular constriction just beneath the mucosa, which causes the ulcer to have a constricted neck or "collar button" appearance. By pushing a portion of the lesser curvature out of the line of

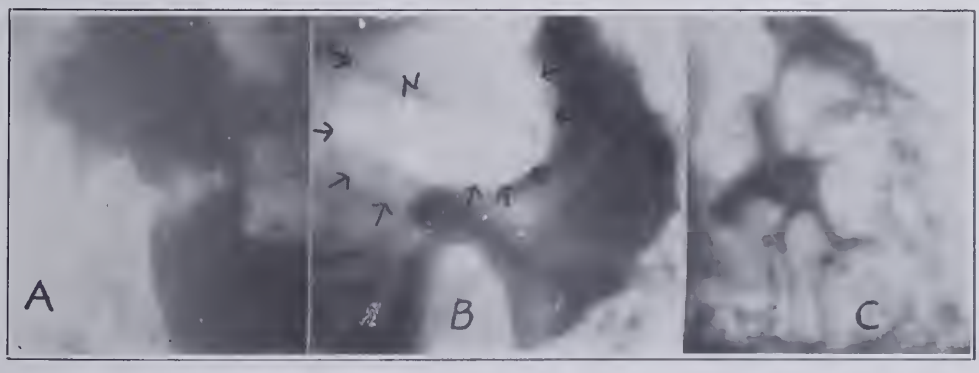


FIG. 7

A, Cap without compression; B, (reversed) with compression, showing annular concave ridge due to edema. (N) Niche.

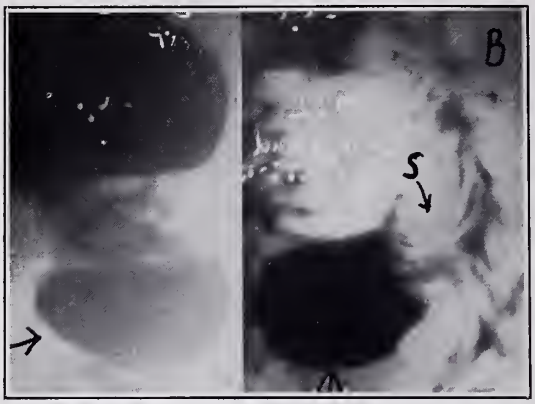


FIG. 8

A, Diverticulum without rotation and compression; B, with rotation and compression, showing stalk of true diverticulum arising from descending duodenum. Arrow points to diverticular stalk (S).

vision, we can best demonstrate the depth of the ulcer and Cole's "collar button".

MARGINAL ULCER

In Figure 9 we see how clearly a marginal ulcer presents itself with use of properly aimed compression technic, as compared to our old type routine antero-posterior films.

As the years pass, we have come slowly to the appreciation of the fact that every patient with any gastro-intestinal complaint is entitled to a complete gastro-intestinal work-up. Since diagnosis can be made roentgenologically long before a patient has typical signs or symptoms, it behooves us as gastro-enterologists to consider the x-ray as our means of physical examination. We must learn to use it to its best advantage.

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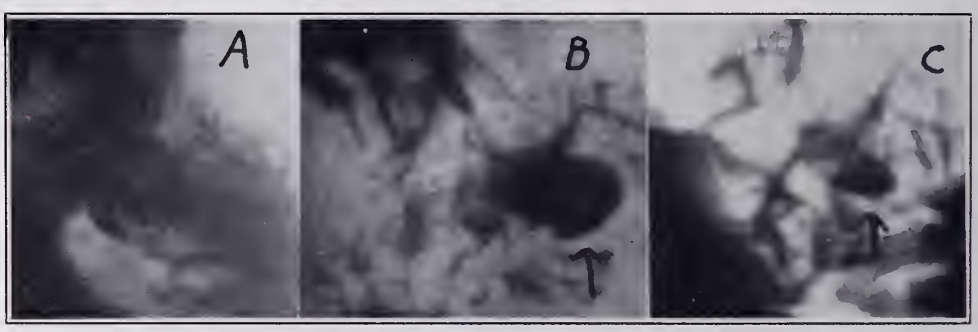


FIG. 9

Jejunal ulcer after gastrectomy; A, without compression; B, with compression; C, after two weeks' medical treatment, the lessened area of the ulcer is evidence of healing.

SUMMARY AND CONCLUSION

Lawrason Brown proved the superior accuracy of x-ray diagnosis over clinical diagnosis for tuberculosis.

Just as the chest specialist today asks first for the "Plates", so should the gastro-enterologist request, above all, his films. He should ask if they were taken in conjunction with fluoroscopy, and if they show a suspicious area to its best advantage.

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STATE SOCIETY ACTIVITIES

PRESIDENT'S ANNOUNCEMENT—NO. 7

NEW YEAR'S GREETINGS

By Spencer T. Snedecor, M.D., Hackensack, N. J.

This series began with the July issue.

Our wish for each member of The Medical Society of New Jersey for the New Year is happiness and prosperity.

An increase in the income of the physician is to be anticipated during this coming year. As the earnings of the people increase and the reserves of each individual family are built up, their willingness to pay adequately for medical service will redound to the benefit of the doctors. We have much to be thankful for in this evidence of returning prosperity.

We are likewise confident that the doctors in 1937 will receive a larger measure of happiness in the pursuit of practice. The reason for this will be their performance of better medical service.

Changing times are upon us, it is true. Health insurance looms even nearer. The problem of medical care to the low-wage groups and the indigent is far from satisfactory. Our relations with many allied professions, such as nursing and pharmacy, should be cultivated. Our hospital associations need to be developed. The public health consciousness and the preventive medical practice of each physician can be improved; and the public must be made aware of our aims and methods.

Summarizing all of our present-day problems, the challenges and the threats which bear directly upon the satisfactory and happy individual practice of medicine, we are yet highly optimistic that the doctor of 1937 will meet these questions, surmount his difficulties, and practice medicine for his own greater happiness and the further welfare of his people.

Best wishes for the New Year!

PERIODIC LETTER TO MEMBERS—NO. 2

The first letter was mailed on October 15th, and was printed in the November issue of this Journal, page 651.

December 16, 1936.

Dear Member:

My purpose in writing this second letter is to tell you about the current activities and problems of your Medical Society. A number of significant events are in the making, and I shall outline them briefly.

1. *A survey on health insurance plans* has just been announced by the Federal Social Security Commission. Many influential groups are clamoring for this legislation as necessary to the fulfillment of the social security program; and the large Democratic majority of the last election will doubtless be reflected in further security legislation. We are contacting the security commission so that we may be associated with any efforts which they may make in the field of health and medical service.

2. *Members of the Medical Society can improve the distribution of their services* through active support of our plans for better medical service which are now in progress. If your society is to succeed with a convincing demonstration of the value of our own efforts and thereby offset governmental action and control, then the physician must lend his energetic aid to carry out his individual responsibility.

3. *Plans for the care of the indigent and low-wage persons* in need of medical care are being discussed by a committee under Dr. Charles H. Schlichter as chairman, and the State relief authorities in charge of supplemental funds. It seems hopeful that a State-wide plan based upon the principle of lowered fees to doctors for the care of these patients, when authorized by the local relief agency as eligible for such services, will again be formulated. (December Journal, p. 714.)

4. Dr. J. H. Kler of New Brunswick has been appointed Chairman of the *Public Relations Committee* in the State Medical Society. Dr. Kler is well fitted for this important post and will contact the County Society Public Relations Committees promptly and discuss with them the program and the proposed activities in each County Society. (De-

cember Journal, p. 716.) We urge each physician to become vocal in expressing his opinions on medical practice, both to his patients and the organizations with which he comes in contact.

5. The *Legislature* is scheduled to meet this month to discuss the social security program as it applies to New Jersey. Now is the time for each member to contact the Senator and Assemblymen in his county. There are many health problems involved and the welfare of each of our members depends at least in part on how insistent the medical men are in presenting their individual and collective views on legislative proposals and bills to their own county representatives in the legislature. Do your part promptly—for *your own sake* as well as that of your profession.

6. This promises to be an important year in *medical history*. The conditions under which we live and practice are changing rapidly in these times. Keep abreast of these actual and proposed changes and be informed as to what is taking place within your own profession. Read your Journal, attend the County Medical Society meetings regularly and take part in all the discussions and activities. (Consider carefully the suggestions made by your own County Society Officers and committees and those presented by the State Society representatives.) You cannot afford to neglect this opportunity to be prepared for the future.

7. The *examination form for bus drivers*, prepared by the Medical Society at the request of the Department of Motor Vehicles, is now printed and being distributed to applicants to take to the examining physician. (November Journal, p. 655.) Your Society has done its part in providing that, as far as practical, these examinations shall be performed by the family physician. We urge that you do your part in making these examinations thorough.

8. If you have some criticism or suggestion regarding the present *Compensation Practice Act*, Dr. J. Irving Fort, of Newark, Chairman of that committee, will be glad to hear from you. He is making a thorough study of the law and its applications, and is seeking an expression of opinion from the members as to their experiences or recommendations.

9. *Post-Graduate Courses* will be offered in your county after the first of the year. A free course in child health will be given through the social security program. Special courses according to the wishes of your society will be arranged through Rutgers as usual. (December Journal.)

10. The plans of the *Maternal Welfare Committee* should be completely known to you. We hope that you will explain your part in better maternal health to each Woman's Club which has this subject as a national feature this year. (December Journal, p. 722.)

11. Under public health, we call your attention to the slogan of Dr. Nichols' committee—*"to make every physician's office a health center"* for the practice of all phases of preventive medicine. In the pre-school examinations, your local contact with the parent-teachers organizations will assist the state committee in their attempt to have these performed by the family physician.

12. Plan *now* to attend the *Annual Meeting* in Atlantic City in April. We expect at least 1,000 doctors to be present for these three days. Come and stay till the last minute—meet your colleagues and enjoy yourself while you profit from the attractive program arranged for you.

Fraternally yours,

Spencer T. Snedecor, M.D.,

President.

PRESIDENTIAL ADDRESS OF J. J. MANN, M.D., PERTH AMBOY

Retiring President of the Middlesex County Medical Society

Delivered December 16, 1936.

For the past several years it has been the custom for the outgoing President to make a few remarks on some philosophical subject related to medicine. This year I desire to break that precedent, and instead I will give an account of my stewardship for the year just ending.

A PAID SECRETARY

The one item that looms up in our society is that it is undergoing a gradual transition from a purely scientific organization to a scientific-business one. More and more has it been shown how necessary the step of hiring a paid secretary has been. The question of putting an extra assessment of $9.00 on each member was not undertaken lightly. We realized that such a step would not be over popular with some. But the thinking men and women of this society, realizing how important is the work of educating the public to our way of thinking, and appreciating how unfair it would be to expect any single committee member to devote practically all of his time to this activity, came forward and willingly paid this amount. I hope that a paid secretary will be a permanent employee of our society, and that the State Society will continue to consider us as one of the progressive County Societies.

We have passed several resolutions which, if carried through as intended, will have a far-reaching and profound effect on the practice of

medicine in this community and will bring home to the general public the power which this society has in this county. I wish to mention the following:

1. TESTING SCHOOL CHILDREN FOR TUBERCULOSIS

I was most gratified to learn that the Middlesex County Tuberculosis League has accepted our proposed method of testing school children by tuberculin and x-ray films under the direction of the County Society. The weight of this society was behind this measure, and full credit belongs to the committee who so ably put it in operation.

2. CONTRACT PRACTICE

Our society has, in a measure at least, taken steps to discourage new contracts which do not have its sanction. This measure requires further elaboration, and I should recommend additional study of this great question.

It is my opinion that the less contract practice a man does, the better his practice will be. If every one in this society were to give up this type of work, it would rebound to the benefit of all of us, including the one who gave it up. The least this society can expect of one of its members is that he submit whatever contract he is about to accept to a committee appointed for that purpose. This committee will study the contract and determine whether or not it is fair to the rest of the profession. It is my hope that the incoming administration sees eye to eye with us in this respect.

3. PATIENTS ON RELIEF

The *"Middlesex Plan"* was adopted, in which we refused to allow any of our members to work for a municipality on relief clients on a contract basis, continuing our "free choice of physician policy", the cost to be paid by the municipality. This plan has been approved by every municipality in the county except New Brunswick and one or two small communities. It again represents a victory for our society, and we expect the plan will soon be adopted throughout the entire county.

FREE CLINICS

The *resolution opposing free clinics,* adopted at our last meeting (page 63), is the most important thing we have done all the year. It is far-reaching and revolutionary in its scope, and ideal as a measure from the standpoint of both the physician and the patient. We have taken our stand definitely, firmly, and determinedly against the establishment of any more clinics in this county; but at the same time, we pledge that each individual patient will receive in our own private offices a type of treatment incomparably better than that he or she could possibly have received in a clinic. True, it is experimental. The State Society officials feel that it can not be worked, although they freely admit that it is by far the best scheme of any devised for all concerned, it is now known as the "Middlesex County Plan". It is our answer to *State Medicine.* Can we afford to let it fail? I plead with each and every one of you to abide by its principles, and do your part. Coöperate and we succeed; shirk and we fail. What is your answer?

MEETINGS

In addition to these important resolutions, this society has had some very interesting meetings. The first, which was addressed by Dr. Fishbein, was widely publicised, and we had guests from all over the State.

The meeting at which we were addressed by the legislators merited the praise which it received. There is no doubt whatsoever that the County Medical Society can and does have a great influence with State Legislators on medical measures.

Our scientific papers have been, I believe, interesting, instructive and varied. The meeting at Marlboro was an innovation, and was well worth the trip.

WOMAN'S AUXILIARY

The Woman's Auxiliary has shown us splendid coöperation. The members have diligently attended their meetings, and the Auxiliary is now on a firm footing. Its particular activity this year has been to work in conjunction with the *Public Relations Committee,* and it has been most helpful in obtaining the many speakers whom we have sent out, and in arranging their talks. This organization should be encouraged and helped because the ladies have an access to the public, through their clubs and other social activities, that we men often lack. They can preach the gospel against state medicine, and I know they do. More power to them; and thanks to Dr. Haywood for getting them organized.

In conclusion, I thank the many members who faithfully and freely gave their time and services to our county, so that it was able to assume the leadership in the administration of public health projects.

SCIENTIFIC EXHIBITS AT THE ANNUAL MEETING, 1937

A scientific exhibit is an essential feature of a medical convention. The committee in charge of the exhibit at the Annual Meeting of The Medical Society of New Jersey in Atlantic City, April 27-29, 1937, is profiting by the experiences of past years, and is adopting those features which will have the maximum appeal to the members.

1. The exhibit room, with the rooms for the meetings, and the technical exhibits, will form a group with the Registration Desk as a center. The group will be on the second, or lounge floor, of Haddon Hall, immediately above the main lobby, and adjoining the dining room and main elevators of the hotel.

2. The perfected arrangement of the exhibit booths and their lighting are shown in the photographs of last year's exhibits, which are now being printed as a series in The Journal, beginning with the December issue.

3. Each booth will have an attendant present to explain its features and answer inquiries. Here a member may have the benefit of a clinical demonstration of the features in which he is most interested.

The official application blank for space contains the following general description of the exhibit:

The Scientific Exhibit will consist of a General Exhibit, and an X-Ray Exhibit.

The General Exhibit will include the demonstration of pathological and clinical material in the form of specimens, charts, photographs, models, etc. X-ray material used in the general exhibit must be in the form of paper prints unless the exhibitor supplies his own viewing apparatus.

Space for the General Exhibit will be assigned according to individual applications. Booths can be arranged for poster exhibits, or with table or shelf accommodations according to specifications in the application. Booths will be constructed with counters thirty inches high. The space above this counter will be six feet high.

Space for X-Ray Exhibit will be assigned according to the needs of the exhibitors, and will be supplied with suitable viewing equipment.

All exhibits must be completely installed before 10 p. m., Monday, April 26, 1937, and must remain installed until Friday morning, April 30, 1937. Booths will be ready for occupancy Monday, April 26, 1937, at noon.

Applications must be in by February 1, 1937.

The exhibit booths are owned by The Medical Society of New Jersey, and are adaptable to the needs of each individual exhibitor. In order that the booths may be properly arranged and equipped, each applicant for space is requested to supply the following information:

1. Title of exhibit.
2. Outline of description,—number and character of specimens, charts, models, etc.
3. Space requirements:
   a. Floor, square feet, each booth being seven and a half feet in depth.
   b. Wall space, that of each booth being six feet in width above the shelf.
   c. Shelf space,—each being seven inches wide and adjustable to height.
   d. Electric outlets.
4. Will motion pictures be used?
5. X-Ray Exhibit, number and size of films. Amount of illuminated space required.
6. Has this exhibit been shown in whole or in part at any other scientific meeting? If so, when and where?

Painted signs will be supplied to the exhibitor, of a uniform size, style, and color, if the following information is supplied:

Title, and sub-title.
Name of exhibitor.
Institution.
City and State.

The Committee on Scientific Exhibits

ASHER YAGUDA, *Chairman*
W. J. MARQUIS
ROBERT A. KILDUFFE
CARLOS A. PONS
HARRISON S. MARTLAND
JOHN W. GRAY
ELWOOD E. DOWNS
HARRY J. PERLBERG.

SCIENTIFIC EXHIBITS AT THE ANNUAL MEETING, 1936

ARTICLE NUMBER TWO

By Asher Yaguda, M.D., Newark, N. J.
Chairman, Committee on Scientific Exhibits



Photograph Number 5.—Symposium Upon the Senile Heart. Drs. Albert S. Hyman, Sante Diasio, Ethel D. Stoliar, Clara Di Benedetto and Elias Shayness, Hospital for the Aged, Bronx, N. Y.

1. There is a definite clinical entity which can be called the "senile heart", and which is concerned with degenerative changes in the blood vessels and heart muscle. In a study of nearly 5000 individuals at the age of sixty-five and over, certain so-called "normal degenerative changes" were found. While these changes are standard for the age group, they may nevertheless indicate considerable pathology when compared to those in normal individuals in the younger age group. The application of the younger age group standards in measuring cardiovascular pathology in the senile heart gives a false impression of the true cardiovascular status of the individual.

2. The conception of the senile heart with its own standards presents a more scientific basis in the question of prognosis and treatment. The prognosis in certain pathologic conditions is very much more favorable when it occurs in the senile heart group than in the younger age periods. Auricular fibrillation, for example, following coronary thrombosis has a more favorable outlook in the senile heart than in the middle age. Other specific types of pathology have also been studied.

3. The response ot standard methods of therapy in the senile heart group varies considerably from that seen in the younger age periods. A common drug like digitalis, for example, has an entirely different pharmacological response in this group. Other drugs have also been studied in this connection.

4. A better understanding of the senile heart both from the point of view of diagnosis and treatment will render a more favorable

prognosis among a group in the community which occupies a most important place. To prolong their lives and to continue their useful services is a chief function of this study.

This work has been carried out under the provisions of the Surut Fund for the Study of the Senile Heart at the Hospital of the Daughters of Jacob, New York. This is one of the largest private institutions in the world devoted exclusively to the study and care of the aged. The problem of diet, exercise, recreation, habits of sleep, medication, and similar questions are now being investigated in a five-year plan. The work will subsequently be incorporated in a volume to be called "The Senile Heart". The last book to appear on this subject was published by Balfour in 1894; there has been no scientific study of this problem since. The exhibit shown at the 1936 Scientific Exhibit of the Society was a part of the work obtained during the first two years of the study.



Photograph Number 6.—Treatment of Fracture of the Neck of the Femur by Axial Fixation with Steel Wires. Drs. D. R. Telson and N. S. Ransohoff, Elberon, N. J.

Fractures of the neck of the femur have long been referred to as the unsolved fractures; and summaries of results of these fractures treated by the conservative methods have been few and most distressing in the hands of the best orthopedic surgeons. Treatment by plaster fixation has resulted in an average of about 50 per cent union, and the death rate somewhere in the neighborhood of thirty-three and one-third per cent.

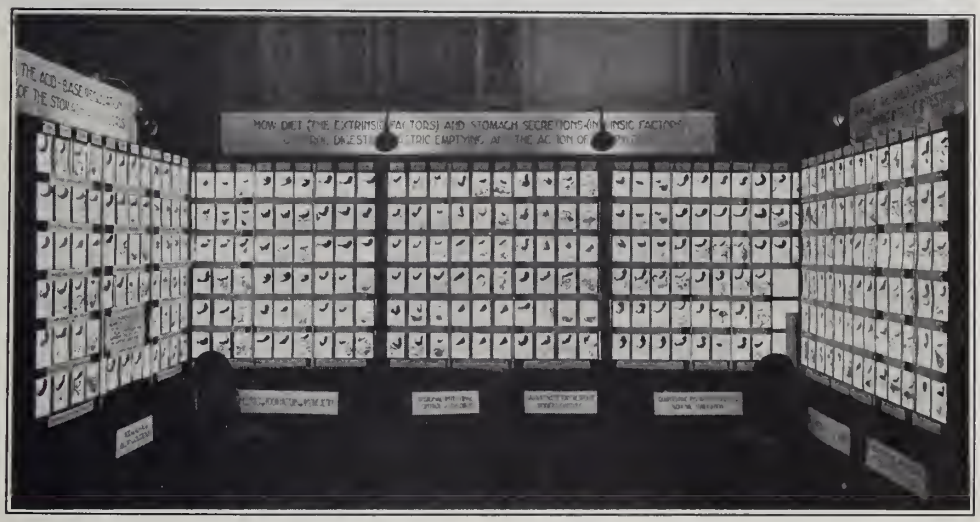
The method of treating fractures of the neck of the femur by internal fixation is becoming more and more a recognized necessity. This method, which presupposes accurate reduction, is, we feel, the simplest of the methods so far presented. It consists of an accurate reduction by means of the Leadbetter manoeuver, and then fixing the hips by means of an eighty-one thousands of an inch threaded, rustless steel wire. These are inserted by means of a hand drill, or a Jacobs' chuck attached to the Albee saw. The wires are clipped off close to the bone and allowed to remain in situ.

We feel that this method insures a maximum degree of comfort for the patient. It reduces the hazard of pneumonia and increases the rate of healing. To the present time we have a death rate of about 20 per cent in the unselected cases, and we have solid union in about 90 per cent of the remainder.



Photograph Number 7.—Hormones in Relation to Breast Tumors. Dr. Charles F. Geschickter, Baltimore, Md.

The exhibit of hormones in relation to breast tumors showed that oestrin may be a factor in the pathological enlargement of the female and male breast known as *virginal hypertrophy* and *gynecomastia* respectively. The fibroepithelial hypertrophy of isolated portions of breast tissue resulting in fibroadenoma is a related condition. The formation of large blue dome cysts is also related to the effect of oestrin and its withdrawal; or of oestrin, or oestrin plus lactogenic pituitary substance, on the female breast. The exhibit showed the results of assays showing the presence of oestrogenic substance in these conditions, and of oestrin and lactogenic substance in cystic disease, together with the technic of assays on the blood and tissues.



Photograph Number 8.—Experimental Studies in Gastric Physiology in Man. Drs. J. Gershon-Cohen and William Shay, Philadelphia, Pa.

This exhibit details a series of chemical and roentgen studies of the stomach and duodenum in man in which the local mechanism controlling the action of the pylorus was examined. The rôle of the intrinsic gastric acid response, of the osmotic tension of salt and sugar in the diet, the effect of proteins and fats, and finally the location of the reflex mechanism controlling the action of the pylorus were demonstrated in pen and ink drawings reproducing the roentgenograms made during these studies. The control of pyloric action seems based on stimulation or irritation of the duodenal mucosa, and this stimulation is very diversified;

a concentration of hydrochloric acid above 0.2 per cent, fat, condiments, hypertonic or hypotonic solutions, or mechanical irritation are all stimulants that can reflexly cause closure of the pylorus. In gastric emptying, of all the factors involved, the action of the pylorus seems to be the most important. These studies were limited entirely to the local mechanism involved, and did not include a consideration of the more remote neurogenic factors.



Photograph Number 9.—Diverticulosis and Diverticulitis of the Colon. Drs. C. F. Baker and W. J. Marquis, Newark, N. J.

The exhibit pertaining to *Diverticulosis and Diverticulitis of the Colon* was undertaken in order to demonstrate, if possible, the difficulty in making a differential diagnosis between carcinoma of the sigmoid and diverticulitis of the sigmoid.

In addition, an effort was made to find out the incidence of the disease in our own practice. At the same time, a review of the literature as to the causes of diverticula was made and correlated with our own findings.

The results of our studies were as follows:

There were sixty-four cases in a series of 480 colon examinations.

There were forty women to twenty-four men affected.

It is commonly accepted that diverticula of the colon do not have any muscular coats in the walls of the sacs.

We have noted upon fluoroscopic examination an apparent contraction of the sac, indicating that there may be some muscle tissue in the walls of some diverticula. No one method of roentgen examination is superior, and the operator must depend on a combination of all.

Diagnosis of simple diverticulitis is usually easy and definite.

Diagnosis of diverticulitis must often be made on evidence of spasm in the sigmoid without direct demonstration of diverticula, in individuals presenting clinical findings which are not inconsistent with such a diagnosis.

Differential diagnosis between carcinoma and diverticulitis may be very difficult.

Six cases are presented, arranged in pairs so grouped that one of each pair was carcinoma and the other diverticulitis; and one of each group presented some feature common to both diseases. (See p. 29.)

CONFERENCE OF ALLIED MEDICAL PROFESSIONS

The Third Annual Meeting of the Conference of Allied Medical Professions was held December 9th in the Executive Offices of The Medical Society of New Jersey, Trenton.

The meeting was called to order at 2:40 p. m. by J. S. Owens, D.D.S., Chairman.

Present: Dr. John S. Owens and Dr. E. H. Peplow, representing the dental profession.
Dr. Robert P. Fischelis and Mr. Henry D. Kehr, representing the pharmaceutical profession.
Miss Margaret Ashmun and Miss Grace Watson, representing the nursing profession.
Dr. Stanley Nichols, Dr. Thomas K. Lewis and Dr. LeRoy A. Wilkes, representing the medical profession.

This being the Annual Meeting, the primary purpose was to select officers for the ensuing year. Chairman Owens reported that the year had been a quiet one, and little occasion had arisen for holding meetings of the Conference.

The Treasurer, Dr. Nichols, reported a balance of $100.21.

It was regularly moved and seconded to have bills for dues mailed to the member organizations for the annual contribution of $25., provided in the by-laws. Since the coming year is likely to be more active, funds should be available for immediate use.

Dr. Fischelis called attention to the fact that it might be well to have representatives of the respective examining boards within the membership of this group, or as conferees.

Dr. Lewis pionted out that the number of representatives is not actually limited. Three was the number suggested, but it was not necessarily limited to that number.

Dr. Fischelis, who represents the Conference of Allied Medical Professions on the New Jersey Social Security Commission, discussed briefly some of the points being considered in connection with this law. He stated that he is informed, on what he considers to be reliable authority, that it is likely that Congress will be called upon to act on a bill to legalize a health insurance plan within a year.

Most of the time was spent on discussion of health insurance, following Dr. Fischelis' report.

It was agreed that there is an opportunity in New Jersey to set up a plan for health care in accordance with what the various professions feel is an American ideal.

Dr. Lewis suggested that each group be prepared at some time not very far distant to report the attitude and philosophy of its own organization toward the whole matter of health insurance, with the idea that in this way each organization would be able to arrive at an understanding of the problems and reactions of its allied professions.

Dr. Owens moved that a special meeting of the Conference of Allied Medical Professions be called for a preliminary discussion of the problems involved in health insurance. Dr. Lewis seconded the motion, and it was unanimously carried.

It was agreed that a representative of each of the four groups would notify the chairman when they are ready for this discussion, informing him of the number of their members who will be in attendance at the meeting.

Dr. Nichols suggested that each group might begin immediately a detailed study of health insurance, so that no time would be lost in getting to work on a general plan.

A motion was made and unanimously passed that this Conference recommend to the four professions an immediate and continuing study of health insurance.

The following officers were unanimously elected:

Chairman, Miss Seifert.
Vice-Chairman, Dr. Nichols.
Secretary-Treasurer, Dr. Peplow.

The new Secretary was instructed to send out the bills for the coming year, covering the assessment of $25, to each of the member organizations.

Meeting adjourned at 4:00 p. m.

Stanley Nichols, M.D.,
Secretary.

THE NEW JERSEY CONFERENCE OF SOCIAL WORK

On December 3rd, 4th, and 5th the 35th Annual Meeting of the New Jersey Conference of Social Work took place at the Hotel Berkeley-Carteret, Asbury Park, N. J.

There was an exceedingly large attendance, conservatively estimating between five and six hundred persons. In addition, there was an extensive exhibit.

There were daily morning, afternoon, and evening sessions, interspersed with luncheons and dinners.

Among the celebrities speaking were: Frank

Kingdon, President of the Conference; James S. Plant, M.D.; David Fales, Jr.; Paul Lazarsfeld, Ph.D.; Julius Levy, M.D., Bureau of Maternal and Child Health; John W. Haggard, M.D., Professor of Applied Physiology, Yale University; William J. Ellis, Commissioner New Jersey State Department of Institutions and Agencies; Ralph T. Levin, M.D., New York.

On Friday afternoon, December 4th, Professor John W. Haggard spoke on "Health and Social Change". In his characteristic vigorous expression, he pointed out that organized medicine all through the ages has led the fight for social and health improvement for the masses. He cited particularly what science had achieved in the diagnosis and treatment of venereal disease, and how the government and social agencies had lagged in their efforts in coöperation with the medical profession. He urged that more missionary work be done on the part of the intelligent lay groups to spread the gospel of prevention, and to bring under control those who are not receiving treatment.

He also spoke of the cancer problem, and pointed out to his large audience how they might aid in bringing the patients for earlier diagnosis and treatment.

This particular session was attended by a number of officers and members of the State Society. Among them were: Dr. Spencer T. Snedecor, Hackensack, N. J.; Dr. James Fisher, Asbury Park; Dr. Stanley Nichols, Asbury Park; Dr. Harold Kazman, Long Branch; Dr. W. H. Fairbanks, Freehold; Dr. O. K. Parry, Asbury Park; Dr. McKenzie, and many others.

At the conclusion of Dr. Haggard's address, various members of our State Society sat in with various groups of the social workers so as to determine the trend of their questions and arguments, and also to answer any questions that might be asked.

O. R. HOLTERS, M.D., *Reporter,*
The Monmouth County Medical Society.

REGIONAL CONFERENCE ON HOSPITALS

At the last Annual Convention of the New Jersey Hospital Association, held on June 5 and 6, a special session was assigned to the subject of determining hospital policies in the light of the several component factors. The approach was from the points of view of the trustee, the doctor, and the administrator. This symposium brought out many illuminating facts of community social relationships. Its effectiveness was evident by the interest which has since been shown in matters of mutual interest.

In order to bring together the representatives of these medical institutions and to promote a feeling of "comraderie" among the members of all the groups, the President of the New Jersey Medical Society and the President of the New Jersey Hospital Association arranged an informal dinner of the trustees, members of the senior medical staffs, and the superintendents of the hospitals in Bergen and Passaic Counties, which was held Wednesday evening, November 11th, at the Swiss Chalet. Over 100 persons were present.

The program of the meeting was as follows:

Toastmaster: Mr. Edgar C. Hayhow, President of the New Jersey Hospital Association.

Introductions of Presidents of Boards of Governors and Superintendents of Hospitals, by Mr. Hayhow.

Introduction of Dr. Spencer T. Snedecor, President of The Medical Society of New Jersey, by Mr. Hayhow.

Ten-minute talks on Hospital Problems from the Medical Viewpoint.

The Medical-Dental Service Bureau,—Dr. Norman Dingman, President of the Passaic County Medical Society.

Nursing Problems from a Doctor's Viewpoint.—Dr. John Irwin, President of the Bergen County Medical Society.

Financial Investigation of Clinic and Ward Patients,—Dr. Russell K. Tether, Chairman of Clinic Committee, Bergen County Medical Society.

Staff Relationships of Paterson General Hospital.—Dr. Thomas Clay, President of the Staff of Paterson General Hospital.

A Plan for the Regulation and Promotion of Surgical Ability.—Dr. Charles H. Schlichter, Surgical Director of Elizabeth General Hospital.

It is proposed to hold another dinner in order to provide the opportunity for hospital trustees and doctors to consider problems of mutual interest to both groups.

CONTACTS AND COMMENTS, No. 3

NURSING BOTTLE, OR POWDER HORN?

Is this a picture of a baby's nursing bottle made out of a cow's horn?



The specimen was bought in an antique shop in Trenton where it hung with a number of horns that were unquestionably used for carrying gunpowder; but its peculiar construction is suggestive of its probable use as a baby's nursing bottle. Its nipple, A, is long and crooked, and is screwed into the neck of the horn. A collar was left near its tip when it was turned on a lathe; and the diameter of its central canal is too small for the flow of grains of gunpowder.

The neck of the horn is in two parts which are accurately fitted together as shown at B. The union is probably by means of a screw thread, but to attempt to unscrew the parts might mar or destroy the horn.

The entire horn is beautifully polished and clean, and is without a sign of a scratch,—a condition which would be impossible if the horn had been carried as a gunpowder flask.

All the characteristics of the horn fit into the theory that it was used as a bottle for feeding a baby. Pediatric books of the sixteenth century contain pictures of babies taking their food from cow's horns. Dr. George Armstrong, an early English pediatrician, recommended a cow's horn as a feeding bottle.

The bottle shown in the picture was collected by an antique dealer in Lancaster County, Pennsylvania, where it is a general practice of the people to keep their discarded furniture and household utensils stored in their attics or hung in the unfinished lofts of their kitchens. It is entirely possible that the horn may have been used by some family in Lancaster County as a nursing bottle.

Can anyone supply information about nursing bottles made from cow's horn?

HEALTH RHYMES

The New York Herald Tribune of January 7 quotes Dr. Allan Abbott, Professor of English in Teachers College, Columbia University, that Mother Goose health rhymes should be rewritten to conform to modern scientific knowledge; and proposing the following substitutes for two well-known rhymes:

"Little Nancy Neppins
In her silk step-ins
And her half hose;
The longer she stands,
The colder she grows."

"Fee, fie, fo, fum!
I taste the Forhans on my gum;
Be it alive, or be it dead,
I still can manage whole wheat bread."

It would seem that the good professor is astray in his interpretation of child psychology. To a child three or four years old a pet cat, for example, is an exemplification of adult wisdom and skill, for it is able to perform its toilet, climb out of harm's way, obtain its food, and behave with the decorum of a lady.

A cow is an embodiment of strength and activity, and could "jump over the moon" if it had to.

The little dog has a sense of humor which is lacking in the child's parents; and the dish often "runs away with the spoon"—at least we remember that our grandmother often said so when she missed a silver spoon.

On the other hand, we cannot imagine a child understanding "step-ins" and "half hose" or whole wheat bread.

The best set of "Health Rhymes" that we have seen is that of the Metropolitan Life Insurance Company, which may be had for the asking.

The child that is learning to read will take a real interest in learning the rhymes that are in the Metropolitan's "A B C" book.

THE HEALTH OF TRENTON

An item in the A. M. A. Journal of January 2, 1937, page 53, says:

"Telegraphic returns to the U. S. Department of Commerce from eighty-six cities with a total population of thirty-seven million for the week ended December 19, indicated that the highest mortality rate (24.8) appeared for Trenton and the rate for

the group of cities was 12.9. The rate for Trenton the corresponding week of 1935 was 18.8 and that for the group of cities was 12.3. The annual rate for the eighty-six cities for the fifty-one weeks of 1936 was 12 as compared with 11.4 for the corresponding period of 1935. Caution should be used in the interpretation of these weekly figures, as they fluctuate widely. The fact that certain cities have a large Negro population or that they are hospital centers for large areas may tend to increase the death rate."

This explanation is unsatisfactory, for Trenton is not a hospital center for a large area, and its negro population is not large (8000 in a total population of 125,000).

The fallacy of the A. M. A. figures for Trenton may be easily demonstrated.

A mortality rate is the number of deaths occurring in each 1000 of population during an entire year.

The following table shows the computation of the number of deaths that would occur in Trenton if the two A. M. A. rates, and the actual rate of 1935, were applied to the city, which has a population of 125,000.

	Number of Persons Dying in Trenton	
Mortality Rate	In an Entire Year	In Each Week
24.8	3100	60
12.9	1600	30
11.1	1393 (official number)	26

In any city the number of deaths that occur varies enormously from day to day, and week to week. It may well be that sixty deaths occur in Trenton in some one week, while only fifteen occur in each of a dozen other weeks.

The fact is that when any one week is singled out and its death rate is applied to a whole year, the total variation (error) is *magnified* fifty-two times. The effect is the same as that of magnifying a photograph of a face fifty-two times, whereby its defects are made to appear glaring. On the other hand, when a photograph of a face is reduced in size by photography, the defects disappear, and the portrait is excellent.

The actual death rate in Trenton for the year 1935 was 11.1, according to the statistics of the New Jersey Department of Health, indicating that the health of the people of Trenton is better than the average for the cities quoted in the A. M. A. Journal. There is every reason to believe that Trenton's death rate for 1936 will be found to be about the same as that for 1935.

Among the measures proposed in the series of "President's Announcements" is a wider recognition of the county medical societies. The Publication Committee considered the present reports of county society meetings and activities, and decided to increase their scope by the use of photographic and word pictures of outstanding members. Two interesting contributions are published in this issue in the department of County Society Reports.

The contribution from Bergen County features the Annual Banquet, and contains the photographs of the living Past Presidents and the design of the lapel pins with which they were presented.

In response to the request of Salem County, the portrait of Dr. John M. Summerill, of Pennsgrove, is printed, together with an outline of his career of over sixty-one years in the continuous practice of medicine in his native community. The response of the members of the State Society is indicated by the remark of one of the Past Presidents that he would make a special trip to Pennsgrove to become acquainted with Dr. Summerill.

With these two excellent examples as demonstrations, other county medical societies should feel encouraged to send photographs of members and groups and descriptions of their contributions to the appreciation of medicine by the people.

The address of Dr. J. J. Mann, on completing his term as President of the Middlesex County Medical Society, is well worth reading (page 44). The physicians of Middlesex County are still doing original things, as they were when they assumed the leadership in founding The Medical Society of New Jersey in 1766. Dr. Mann shows that the Middlesex County doctors have original ideas as to the methods to apply in solving their problems in medical relations. They prefer to deliver the services of medicine by means of their own local resources, instead of depending upon the aid of the State, or the Federal Government. It would seem that the Middlesex doctors prefer to seek aid from their own local officials rather than from State or national sources.

The fifty-fourth annual report of the *Society for the Relief of Widows and Orphans* of Medical Men of New Jersey shows that the organization is in a sound financial condition. Its relief consists in a one-dollar assessment on every surviving member, to be paid to the widow. Sixteen members died during the year, leaving 494 as the present membership. Its permanent fund is now $57,517.00.

The promotion of the society is one of the major activities of the Woman's Auxiliary.

If a physiican will read the article on Gastric Polyposis in the November Journal, page 615, and compare it with the three articles dealing with diverticulosis, on pages 21-42 of this issue, he will get a conception of two opposite gastro-intestinal conditions which have often been confused.

In polyposis, a pear-shaped tumor projects *into* the hollow part of the stomach or intestine; while in diverticulosis, the hollow cavity balloons outward through a weakened part of the intestinal wall, like the inner tube of an automobile tire through a large puncture in the outer casing. The value of the articles to the general practitioner of medicine is that their contrast will impress the two opposite conditions on his mind, and will assist him in understanding the interpretation of x-ray films of the gastro-intestinal tract.

The Bulletins of the County Societies are doing an excellent service in calling attention to the activities of the State Society, and thereby supplementing the information contained in the Journal, and the President's personal letter which is sent to each member, the second of which is reproduced on page 43 of this Journal.

The Bulletins also contain items of information which come to the Executive Offices from no other sources. They help to unite the medical profession of New Jersey into one common brotherhood.

Camden.—The December Bulletin of Camden County contains the following account of the way it is dealing with quacks:

> Unlicensed practitioners, quacks, and vendors of nostrums are still plying upon the public in our county. Cases coming to the attention of physicians should be reported to the office of the Secretary of this county. They will be investigated and prosecuted by the State Board of Medical Licensure. Three cases were successfully prosecuted in this county during the past year. There is no publicity attached to the informant, as the prosecution is handled entirely by the Board.

Atlantic.—The Bulletin of January contains the following practical suggestions by President Salasin, who is also health officer, for preventing hay fever:

> Something in which I should like to see the County Society take more interest is the eradication of ragweed from Absecon Island. This does not seem an impossibility, and I feel sure that we could attract many hay fever sufferers to Atlantic City if we could assure them of pollen-free air at least 60 per cent of the time.

President Salasin also calls attention to the necessity that family doctors should be scrupuously careful in reporting births.

> From time to time the Department of Health has been confronted with a condition as follows:
>
> A son or a daughter in the late teens comes to this department for a birth certificate for various purposes—going abroad, and the like—and we are unable to find such a record. If truth is stranger than fiction, little need be said about the importance of the registration of the baby's birth. How many exciting stories are based upon the mystery surrounding the circumstances of a child's birth! In later life it may be that a child will have urgent need of a record of his birth. The question of a child's age is often raised, especially his right to go to school or work. It is necessary to produce a birth certificate in order to procure passports to travel abroad. Fortunes have been lost by failure to establish age or parentage. It is absolutely necessary that accurate knowledge of the births be obtained in order to keep and preserve true records of the people within a community.
>
> I do not have to review the law to the practitioner; but it is easy at times to procrastinate, and then finally forget, and in so doing impose a severe injustice upon some individual.

We are here reminded that it would be an excellent idea to prepare and publish a description of the method by which an adult person can have a certified statement of his birth filed in both the local and State departments of health. (*Editor's Note.*)

Physicians are reminded of the *Tumor Clinic* in the following note:

> The tumor clinic of the hospital has reviewed its work for 1936 and made plans for 1937. Some three hundred cases of cancer and conditions simulating cancer were studied and treated in the Surgical or Roentgenological Departments.
>
> It is hoped that all patients in whom cancer is suspected, whether from the out-patient departments or from the wards, or under the care of outside physicians, will be referred to the Tumor Clinic for study. They will be referred back to their physician, with an opinion and suggestons for treatment.

21295

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

January, 1937				February			
5	Camden	14	Passaic	2	Camden	11	Essex
5	Hudson	19	Warren	2	Hudson	11	Passaic
8	Atlantic	20	Middlesex	9	Bergen	11	Somerset
12	Bergen	21	Gloucester	9	Cumberland	12	Atlantic
13	Mercer	26	Hunterdon	10	Mercer	12	Salem
13	Ocean	27	Monmouth	10	Ocean	17	Middlesex
14	Burlington		Sussex (At call	10	Union	18	Gloucester
14	Essex		of President)	11	Burlington	24	Monmouth

ATLANTIC COUNTY

E. H. Nickman, M.D., Reporter

The annual business meeting of the *Atlantic County Medical Society* was held December 11, 1936, at the Ambassador Hotel, with President S. L. Salasin presiding, and fifty-eight members and guests present.

Dr. A. J. Casselman presented a short discussion on the handling of venereal diseases in the state clinics, and urged better coöperation from the physicians in reporting cases and treatment.

MEMBERSHIPS

Dr. B. M. Lawther was accepted as a member of this society.

Dr. D. B. Allman, Chairman of the Board of Censors for 1937, requested that all new applications should not only come before the society, but that any member who knows the applicant should pass on whatever knowledge he has to the Board of Censors so that a proper acceptance or refusal can be made.

Resignations from membership were accepted from Dr. Henry James, Mays Landing, and Dr. Joseph H. Marcus, of New York City, and they were made honorary members of this society.

PUBLIC HEALTH

Dr. E. H. Harvey, Chairman of the Public Health Committee, reported that the State Committee on Public Health had requested each county committee to include in its membership a representative of each of the following divisions of practice: Cancer control, maternal welfare, tuberculosis, mental hygiene, crippled children, child health, and venereal disease control. The object of the added members is that all of these problems coming before the county societies can be properly handled with reference to the Social Security plan of this State.

Appointments to the Baby Keep-Well Stations were made as follows: For Atlantic City: Drs. W. B. Stewart, E. H. Nickman and B. Crane; for Buena Vista, Dr. S. Goldstein.

It was also announced that the Department of Child Hygiene had sent out two nurses in the colored section with the idea of starting Baby Keep-Well Stations in that district. If such stations are opened, the physicians now in the present stations will be called upon to instruct colored physicians for their new work.

MEDICAL ECONOMICS

Dr. H. L. Harley reported that while a large amount of data had been collected for the Committee on Medical Economics, there is still considerable work to be done; and he requested a further extension of time for the completion of this report. Dr. Barbash stated that if it could be held over until February or March, the 1936 figures could be included.

GRADUATE EDUCATION

Dr. G. R. Stamps gave the report for the Medical Education Committee in the absence of the Chairman, Dr. W. J. Carrington. Seventy-one members attended the lectures in 1936 on endocrinology and neurotherapeusis which were held in the Solarium of the Atlantic City Hospital. The committee recommended that the lectures in 1937 be held early, so that they will not conflict with the pediatric lectures; and that they be held in the solarium of the hospital again.

NEWSPAPER PUBLICITY

Dr. W. B. Stewart reported for the *Liaison Committee for Newspaper Release* in the absence of Dr. Carrington, stating that the medical articles published in the press had been widely read and that parts of many of them were being used in nation-wide advertising of Atlantic City.

THE BULLETIN

Dr. S. Barbash, reporting for the Publication and Publicity Committee, stated that advertisements secured by Dr. Hoffman would bring $560 to the society's treasury, $240 of which is needed to pay for the printing of the Bulletin, and the balance to go in to the Treasurer's funds.

Dr. E. H. Nickman has been appointed Associate Editor of the Bulletin.

There was discussion from the floor as to whether or not the society should continue sending out the Supplement with the Bulletin; and it was suggested by Dr. Salasin that the matter be held open for discussion until the next meeting.

MATERNAL HOMES

The application for a maternity home in Pleasantville by Mrs. Harffey was approved by the Maternal Welfare Committee.

Two more applications for maternity homes, one from Mrs. Robert Paynter, Hammonton, and one from Mrs. Elsa Male in Pleasantville, were referred to the committee for action.

ELECTION OF OFFICERS

The following officers were elected for 1937:

President, John S. Irvin
Vice-President, Hilton S. Read
Secretary, J. Carlisle Brown
Treasurer, David B. Allman
Reporter, E. H. Nickman
Historian, H. L. Harley

Member of Board of Censors, S. L. Salasin

Delegates to State Society (term expiring 1940):

Delegate	Alternate
S. L. Salasin	Charles Hyman
Hilton S. Read	W. B. Stewart
(If membership entitles an additional delegate)	
S. Barbash	A. G. Merendino

Member of State Nominating Committee, Dr. D. W. Scanlon

Delegates to other County Societies: William O. Roop, Claude Fish, Sloan Stewart, Cole Davis, I. R. Buro, and H. I. Silvers.

Adjournment.

BERGEN COUNTY

LeRoy W. Black, M.D., Reporter

The regular monthly meeting of the *Bergen County Medical Society* was held at the Memorial Hospital, New York City, on December eighth. The meeting was different from the usual in that the members of our society were guests of the Staff Physicians of the Memorial Hospital, who presented the subject of "Cancer".

Dr. James Ewing opened the meeting and spoke on "The Wide Variety of Cancer in the Various Organs of the Body", indicating the need for greater study of all cases.

Dr. Frank Adair showed two "breast tumors" removed in the morning, and said that 72 per cent of women with tumors of the breast without axillary involvement live five years or more after treatment. If there is axillary involvement, only 23 per cent survive for five years after treatment.

Dr. Lloyd Craver spoke on "Thoracic Tumors", and demonstrated two cases which had had divided high-voltage x-ray treatment.

Dr. Ralph Herendeen presented a "bone tumor" which had been satisfactorily treated with x-rays.

Dr. Norman Higgenbottom showed a case of "Osteogenic Sarcoma of the Humerus".

Dr. Benjamin Barringer showed a case of "Carcinoma of the Prostate with Metastasis to the Bladder"—alive and well after seven years. He presented a case of "Teratoma of the Testicle", alive and well after eleven years.

Dr. Archie Dean gave a history of a "Wilms Tumor of Kidney".

Dr. William Watson presented a "Tumor of the Hard and Soft Palate", satisfactorily treated.

Dr. George E. Binkle spoke upon cases of operable carcinoma of the rectum in poor surgical risks.

Dr. John E. Kelly presented a very interesting case of a woman that had had a carcinoma of the breast, with metastasis to the axilla, satisfactorily treated with x-ray. She came back in a few years with carcinoma of the cervix. He also showed a carcinoma of the ovary which had responded very well to treatment.

Dr. George T. Pack showed two unusual cases; 1, "Kaposi's Multiple Hemorrhagic Sarcoma"; and 2, "Sarcoma of the Stomach".

Dr. James J. Duffy presented a "Naso-Pharyngeal Tumor".

Dr. Norman Treves showed pictures of "Inflammatory Carcinoma of the Breast". The symposium certainly demonstrated that cancer could be taken care of in a fair proportion of cases under a proper regimé of treatment.

Dr. S. T. Snedecor, in discussing the symposium, stated that twenty-five of the one hundred and six general hospitals in New Jersey have to send their cancer cases out of the State.

Dr. J. H. Irwin, our President, took the chair for a brief business session.

NEW MEMBERS

The following were elected to membership:

From Junior to Regular—
Dr. Edward V. Sexton, Teaneck
Dr. A. A. Zacchino, Palisade
Dr. H. R. Magee, Hackensack

To Junior—
Dr. Frederick S. Leonard, Tenafly
Dr. Paul F. Caruso, Hackensack Hospital

Applications for Membership

From Junior to Regular—
Dr. Joseph B. Basralian, Hasbrouck Heights
Dr. E. J. Kakascik, Garfield
Dr. Vincent P. Candio, Lyndhurst
Dr. Kalman Chase, Hohokus
Dr. R. J. Neville, Hackensack

To Regular—
Dr. Joseph T. McGuire, Lodi
Dr. Ralph Brennan, Radburn
Dr. Eufelia Pingatore, Hackensack

To Junior—
Dr. Lewis A. Klein, Teaneck

Meeting adjourned.

The *Bergen County Medical Society* held its annual dinner on November 19th in the Swiss Chalet. This year it paid homage to Dr. Spencer T. Snedecor, Hackensack, a member of this society and now President of The Medical Society of New Jersey; and also to the Past-Presidents of its own society.

Over 200 members and invited guests heard Dr. Snedecor respond to a brief laudatory introduction, with his assurance of appreciation for the honor, and a promise to work for the high ideals of the society. He concluded with some abstracts from



Past Presidents, Bergen County Medical Society.

researches which he is making into the history of medicine and medical men in Bergen County.

Dr. Snedecor was the recipient of a handsomely illuminated parchment scroll, and an engraved silver platter. Mrs. Snedecor had been remembered during the day with a basket of flowers.

Among those speaking briefly were State Senator Winant Van Winkle, Assemblyman Frank Osmers, Assemblyman-elect Roscoe McClave, Dr. William G. Herrman, of Asbury Park, President-Elect of The Medical Society of New Jersey; Dr. Fred J. Quigley, of Union City, President of the Board of Trustees of The Medical Society of New Jersey; Dr. Norman M. Dingman, of Paterson, President of the

Passaic County Medical Society; Dr. Edward W. Sprague, of Newark, Past President of the Essex County Medical Society; Dr. Frank Overton, Trenton, Editor of The Journal of The Medical Society of New Jersey; and John Roe Snedecor, of Patchoque, Long Island, father of Dr. Snedecor.

Dr. Overton read some original verses on "The Old-Time Country Doctor", which are printed in the Bergen County Medical Society Bulletin for December.



President, Bergen County Medical Society

President, The Medical Society of New Jersey

Capped and gowned, the Past Presidents were introduced after a formal procession into the hall. Those answering the roll were Dr. William L. Vroom, Ridgewood, who took office in 1905; Dr. Joseph S. Van Dyke, Palisades Park, 1907; Dr. Alfred W. Ward, Closter, 1908; Dr. J. B. Edwards, Englewood, 1916; Dr. Joseph Payne, Midland Park, 1917; Dr. F. S. Hallett, Hackensack, 1918; Dr. E. N. Huff, Englewood, 1922; Dr. Herman Trossback, Bogota, 1925; Dr. G. W. Finke, Hackensack, 1927; Dr. George M. Levitas, Westwood, 1929; Dr. E. W. Clarke, West Englewood, 1930; Dr. J. R. Morrow, Oradell, 1931; Dr. W. W. Schmidt, Cliffside Park, 1932; Dr. Samuel Alexander, Park Ridge, 1933; Dr. Arcangelo Liva, Rutherford, 1934; and Dr. David Corn, Ridgefield Park, 1935.

Unable to be present but sending messages were the following five Past Presidents: Dr. J. W. Proctor, Englewood, 1911; Dr. G. H. Ward, Englewood, 1912; Dr. Frank Freeland, Hackensack, 1915; Dr. W. Phillips, Englewood, 1920; and Dr. F. O. McCormack, Englewood, 1928.

Each Past President was presented with a lapel pin designed after the seal of the society.



Past President's Pin

The toastmaster, Dr. John H. Irwin, President of the Bergen County Medical Society, presented the speakers and the honored guest of the evening, and introduced each Past President with appropriate comment.

Dr. Walter Farr headed the committee responsible for the affair and was master of ceremonies for the entertainment which followed the dinner and the formal program.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The regular meeting of the *Camden County Medical Society* was held December 1st, 1936, at 9 p.m. It was attended by seventy-three members, and Dr. B. F. Buzby, the President, presided.

NEW MEMBERS

The following new members took the oath of allegiance to the County Society: Dr. E. Hallinger, Dr. David Keyser, Dr. J. C. Jones, Dr. A. S. Hansen and Dr. D. Stephenson.

The Public Health Committee reported that it was attempting to get appropriations from the Social Security Act to provide Baby Keep-Well Stations in the City of Camden.

Dr. A. H. Lippincott gave a report on the City Dispensary.

The following men were proposed for membership:

Dr. G. M. Adams, 304 Monmouth Strect, Gloucester, N. J.

Dr. Kenneth L. Athey, 3616 Westfield Avenue, Camden, N. J.

The scientific program was very interesting and instructive to all.

The following papers were presented:

The first essay was by Dr. C. R. Hutcheson, who discussed the Roentgen Diagnosis.

This was followed by Dr. R. L. Sharp's paper on the Medical Aspect of the conditions.

Dr. H. W. Jack read the third essay, on the Surgical Treatment of non-malignant lesions of the large bowel.

Dr. D. F. Bentley briefly presented the proctological aspect, and discussed the value of the sigmoidoscope in diagnosis and treatment.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

A well-attended meeting of the *Cumberland County Medical Society* was held on December 8 in Millville.

Dr. M. F. Sewall, of Bridgeton, reported the meeting of the Welfare Committee held in Trenton on November 22. He said that the report of the Cancer Committee indicated that Southern New Jersey is lacking in facilities for diagnosing and treating cancer; and advised his colleagues to use those in Camden and Atlantic City.

Dr. I. W. Knight, of the State Board of Health, recalled epidemics that had broken out at which time school boards quickly ordered the children vaccinated. It was shown that several hundred children in Vineland and Landis Township are still untreated, and the society passed a resolution that all boards be advised to make vaccination compulsory, thus making the practice uniform throughout the State.

Dr. Kilduffe, in his address entitled "Paths and Back Roads of Medical History", traced the growth of the hospital for treating diseases for several centuries, referring to the Babylonians, Egyptians, Moslems and Christian countries.

Dr. E. S. Corson traced the pioneer work of the medical missionaries in establishing hospitals on the frontiers of advancing civilization in the Orient, the sacrifices undergone and the improvements gained.

Following the meeting the physicians enjoyed a turkey dinner served by the ladies of the First Presbyterian Church in the social hall.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

A meeting of the *Essex County Medical Society* was called to order at 8:45 p. m., December 10, 1936, by the President, Dr. Edgar A. Ill, at the Academy of Medicine, Newark.

PUBLIC RELATIONS

For the *Public Relations Committee*, Dr. Van Ness stated that this committee had three main functions: 1, Membership on lay boards; 2, contact with lay organizations; 3, the formation of a Speakers' Bureau. The committee is now organizing the Speakers' Bureau, and also a course in public speaking. A great number of members have signified their desire to join such a movement. Several members of the Ladies' Auxiliary have also signified their desire to join also. From present indications, it would seem that there will be a fair number of members to begin this course.

DOCTORS' CARDS IN NEWSPAPERS

Dr. Pinneo spoke of the letter received from the Orange Weekly, asking for permission to print articles regarding doctors' offices, mentioning their names and location. Dr. Pinneo stated that the Council had voted not to grant this publication this privilege, as it was not in line with the principles of the profession. This action of the Council was approved.

FILING SYSTEM

Dr. Ill spoke of the visit to Trenton of Mrs. Miller and Mr. Parket to inspect the filing systems of the State Offices. He stated that the Council had voted to install the same system in the County Office.

NATIONAL HEALTH INSURANCE

Dr. Sprague read the clipping from the New York Herald Tribune of November 22, 1936, entitled: "Health Insurance Study Is Initiated by Security Board". Dr. Sprague recommended that the County Society call the attention of the State Medical Society to this subject and ask the State Society to consider the development of a *plan of procedure* which would enable the State Society to be prepared to deal with any contemplated action pertaining to Health Insurance, or to effectively assist in properly directing legislation before it becomes a fact.

This plan should include the following features:

1. At all times be prepared with the latest information on proposed Health Insurance Plans of the Social Security system with the Federal Government at Washington.

2. Ask the American Medical Association to demand the privilege of conferences of the A. M. A. with the proper committees or officers of the Social Security system, or any other group of officials while they are developing any Health Insurance measures.

3. Resist the inclusion of Health Insurance in the Security Act.

4. Develop a State-wide plan which would be workable; and to be held in reserve, but ready when needed. This State-wide plan to be based on the New Jersey Plan of the E. R. A., which was founded:

a. On the basis of free choice of physician.

b. The individual physician to be paid for the individual case a certain designated fee.

c. That the profession do its own policing and disciplining of the doctor.

We are aware that the E. R. A. cared for only the indigent, while the Social Security Health Insurance Plan would care for only the workers in certain economic groups. It is feasible, however, to develop a plan which would preserve the three principles mentioned. This could be prepared and called *the New Jersey Plan*, and be submitted to the A. M. A. for approval.

Dr. Sprague suggested that this matter be taken up with the Amerian Medical Association, or with the government itself, if legislation is pending or has been enacted on the basis of individual State operation.

5. If an approved plan of procedure has been prepared, the State Medical Societies could then, on short notice, enter into conference with government officials, and would be in a position to definitely state what was needed to give the best medical care to the patient.

On motion, this recommendation was referred to The Medical Society of New Jersey.

MEDICAL-DENTAL SERVICE BUREAU

A comprehensive report was given of the regular monthly meeting of the Board of Trustees of the

Medical-Dental Service Bureau, at which fifteen members were present. The Bureau has nearly perfected its plans to add a collection agency to its present activities.

NEW MEMBERS

The following physicians were elected to regular membership: Samuel Ash, 25 Johnson Avenue, Newark; Charles W. Banks, 6 North Munn Avenue, East Orange; F. Grendon Reed, 144 Harrison Street, East Orange; Kurt Salomon, 732 Lyons Avenue, Irvington; Harry E. Thomison, 605 Broad Street, Newark; Norman E. Weeks, 11 Seymour Street, Montclair.

The following were elected to associate membership: Hyman Seymour Denberg, 14 Leslie Street, Newark; Joseph Di Norcia, 451 North Seventh Street, Newark; Bernard B. Eichler, 159 Bellevue Avenue, Montclair; Jesse Theodore Glazier, 670 Sanford Avenue, Irvington; James B. Gulick, 144 South Harrison Street, East Orange; George L. Kline, 146 North Grove Street, East Orange; Edward T. Lawless, 85 Warrington Place, East Orange; Bernard B. Lilien, 730 Lyons Avenue, Irvington; Donald Marcus, 640 Stuyvesant Avenue, Irvington; Ralph Miller, 55 Wilbur Avenue, Newark; Nicholas M. Rubino, 67 North Fourth Street, Newark; Christopher A. Smith, 6 Park Street, Roseland; Francis S. Weinstein, 189 Sixteenth Avenue, Newark.

THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

Franklin J. Tobey, M.D., Secretary

The stated meeting of the *Academy of Medicine of Northern New Jersey* was held on Thursday, October 15, 1936, and was called to order by President Danzis at 9 p. m.

The annual reports were read by the Chairmen of the Sections and the Secretary.

The following physicians were elected to Fellowship:

B. T. D. Schwarz, M.D., 2787 Hudson Boulevard, Jersey City.

To Junior Fellowship—

Anthony J. Perrone, M.D., 456 Roseville Avenue, Newark.

Dr. Danzis introduced our guest speaker, Dr. Paul Klemperer, Pathologist, Mt. Sinai Hospital, New York, who spoke on the subject, "Newer Aspects of Liver Pathology", which was of great interest to the audience, and was splendidly illustrated with lantern slides.

SPECIAL MEETING

A lecture to the laity was held on Thursday, October 29th, 1936, at the Academy of Medicine of Northern New Jersey, under the auspices of the Committee on Public Health and Medical Education.

The meeting was called to order by President Danzis at 9 p. m.

Dr. Danzis welcomed the audience to the Academy, stating that it was the intention of the Academy to hold meetings for the public at various times during the year. He introduced Dr. Henry C. Barkhorn.

Dr. H. C. Barkhorn, chairman of the committee, after a few complimentary remarks concerning the guest speaker, introduced Dr. Foster Kennedy, Professor of Neurology, Cornell University Medical College.

Dr. Kennedy's paper, "The Organic Background of Mind", was a scientific treatise which was understood and enjoyed by the numerous laity present.

Dr. Barkhorn announed that the Academy would hold two meetings in the Spring for the laity, and invited those present to attend and bring their friends.

The stated meeting of the *Academy of Medicine of Northern New Jersey* was held on Thursday, November 19, 1936, under the auspices of the Section on Medicine and Pediatrics. The meeting was called to order by President Danzis at 9 p. m.

Dr. Danzis reminded the members that they have the privilege of reviewing books for the library, and requested more members to do so. He expressed the sorrow and sympathy of the Academy for the sudden death in the immediate family of Dr. William P. Murphy, who was to be the guest speaker of the section.

Dr. Danzis introduced the Chairman of the Section, Dr. Benjamin Saslow.

Dr. Saslow introduced the speaker of the evening, Dr. Joseph Globus, Assistant Clinical Professor of Neurology, Columbia University. Dr. Globus's paper, "Intracranial Hemorrhage, Varieties and Differential Diagnosis", was of great clinical interest and very instructive to the audience. At the conclusion of the paper, Dr. Globus received a rising vote of thanks.

There being no further business to transact, upon motion the meeting adjourned.

STATED MEETING, DECEMBER 17, 1936

The stated meeting of the *Academy of Medicine of Northern New Jersey* was held on Thursday, December 17, 1936. President Danzis called the meeting to order at 9 p. m.

The following new members were elected: Harold Blauvelt, M.D., 46 Parker Avenue, Maplewood, to Fellowship; Albert Scott Harden, Jr., M.D., 536 Ridgewood Road, Maplewood, and Joshua I. Seidman, M.D., 31 Lincoln Park, Newark, to Junior Fellowship.

Dr. Danzis introduced Dr. Charles Gordon Heyd, Professor of Surgery, Columbia University, and President of the American Medical Association. Dr. Heyd's paper, "Liver Deaths and the Complications of Gall-Bladder Surgery", was illustrated by lantern slides. Dr. Heyd reviewed the functions and the pathology of the liver and gall-bladder, and gave his treatment of the disease of these organs in a very comprehensive manner.

The audience showed their appreciation of his paper by hearty applause and a rising vote of thanks.

The February stated meeting of the Academy will be held on Thursday, 18th, 1937, under the auspices of the Eye, Ear, Nose and Throat Section. The guest speaker will be Ward J. MacNeal, Ph.D., M.D., of New York.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

Dr. Thomas B. Lee, of Cooper Hospital, Camden, gave an illustrated lecture before members of the *Gloucester County Medical Society* at the December meeting of the group on December 17 in the Georgian Room at the Homestead Coffee Shop.

Dr. Lee's subject, "Office Gynecology with Special Reference to Diagnosis", proved very interesting.

OBITUARIES

Resolutions were adopted by the society on the death of four members: Dr. Duncan Campbell, of Woodbury; Dr. Charles D. Pedrick, of Glassboro; Dr. H. Wilson Stout, of Wenonah; and Dr. Samuel Fisler Ashcraft, of Mullica Hill.

An obituary of Dr. Pedrick was published in this Journal of February, 1936, page 112. The obituaries of Drs. Campbell, Ashcroft, and Stout appear on page 70 of this Journal.

Following the meeting the members of the Auxiliary joined the society for supper.

Members present were: Drs. M. F. Lummis, I. W. Knight, H. W. Wright, and W. J. Burkett, Pitman; H. B. Diverty, William Crain, Paul Burkett, Fuller G. Sherman, Dorothy Rogers, William Brewer, C. A. Bowersox and E. E. Downs, Woodbury; H. L. Sinexon, Anthony DiMarino and C. C. Sheets, Paulsboro; B. A. Livengood, Swedesboro; Don Weems, Wenonah; Ralph Venturo, Glassboro; C. I. Ulmer and T. M. Gairdner, Gibbstown; W. G. Harris, Mullica Hill; A. G. Gillis, Clayton; H. M. Fooder, Williamstown; Louis Ruttenberg, Mantua, and I. N. Patterson and R. K. Hollinshed, Westville.

Visiting delegates were: Dr. Muriel Ramsey, Millville; Dr. Weithaase, Vineland, and Dr. J. D. Caggiano, Pennsgrove.

HUDSON COUNTY

John N. Connell, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held on Tuesday, December 1, 1936, at 9:30 p. m., at the Carteret Club, with the President, Dr. J. Lawrence Evans, in the chair.

SCIENTIFIC

Dr. Evans introduced Dr. Charles A. McKendree, Clinical Professor of Neurology at Columbia University, who spoke on the subject "Head Injuries, Their Interpretation and the Treatment of Their Acute and Chronic Symptoms".

The address was discussed by Drs. R. Stockfisch, A. M. Zitani, S. A. Sandler, T. J. Schuck, W. N. Doody.

THE BULLETIN

Dr. Brennock, Secretary, announced that the Bulletin would print the following items:

The election and proposal of members.

The programs.

The reports of the Executive Committee.

Motions made and carried.

Communications of interest to the county society.

MEMBERSHIP DRIVE

President Evans proposed that the society institute a membership drive, stating that there are about 700 physicians in Hudson County, and that approximately 450 are members of the society.

HONORARY MEMBERSHIP

Dr. Hamilton Vreeland, of Ridgewood, who graduated from N. Y. U. in 1885, was made an honorary member of this society, since he is one of the oldest practitioners in the county.

CONSTITUTION AND BY-LAWS

A number of amendments to the constitution and by-laws were proposed to be acted upon at a meeting in January.

LIBRARY

Dr. H. Jaffee reported for the Library Committee that it has plans for the near future.

NEW MEMBERS

The following physicians were elected to active membership:

Peter J. Bonanno, 500 35th St., North Bergen

Erwin K. Gutmann, 980 Summit Ave., Jersey City.

Sidney L. Siegel, 227 North Second St., Millville.

The meeting adjourned at 11:15 p. m.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The annual meeting of the *Mercer County Medical Society* was held at the New Jersey State Hospital on December 9th, President Stone presiding.

The Treasurer, Dr. North, submitted his annual report, showing a substantial cash balance, and the investments to be based on excellent security.

NEW MEMBERS

Sixteen applications for membership were received.

Drs. M. Y. Byer and Henry E. Hale were elected to active membership.

The following physicians were elected to associate membership: Drs. Allman, Borrella, Alice L. Clark, Davis, Jr.; Dietz, Dembinski, Eames, Finkle, Horhovitz, Kohn, Rampona, Rita, and Yates.

ELECTION OF OFFICERS

The following officers were elected for the ensuing year:

President, W. E. D'Arcy

Vice-President, W. R. Little

Secretary-Reporter, A. D. Hutchinson

Treasurer, Harry R. North

Executive Committee: Wilbur Watts, E. B. Beairsto, A. J. Fessler

Board of Censors: G. W. Williams

Delegates and Alternates to State Convention

A. D. Hutchinson	B. D. Lavine
H. R. North	J. H. McCullough
J. S. Vanneman	J. F. Pessel
	P. J. Warter

Member of State Nominating Committee: Harry R. North

Alternate: D. Leo Haggerty

After adjournment, refreshments were served in the hospital under the direction of President Stone, who is Superintendent.

MIDDLESEX COUNTY

Charles H. Calvin, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on November 18th, 1936, at "The Pines".

SCIENTIFIC

Dr. J. J. Mann, President, introduced the principal speaker of the evening, Dr. Charles Mazer, Assistant Professor of Gynecology and Obstetrics, Graduate School of Medicine, University of Pennsylvania; Gynecologist to Mt. Sinai, and to Northern Liberties Hospitals, who gave a practical address on "Complications of Pregnancy".

(An abstract of this paper will be printed in the February issue of the Journal.—*Editor's note.*)

The address was discussed by Drs. Lund, Rothschild, and Berkow.

ADDRESS BY DR. HAWKES, OF THE PRESIDENT'S CABINET

A short talk was given by Dr. E. Zeh Hawkes, Second Vice-President of the State Society, with lantern slides showing the State Medical Society's program for the years 1936-37, and illustrating its activities. The program is intended to secure a closer union between the State and the County Societies, and to develop a closer interest in the State Society by every physician.

ADDRESS BY SECRETARY MORRISON

Dr. J. B. Morrison, Secretary, State Society, read a very interesting paper entitled "Should Medical Service Be a Social Responsibility?" This is an attempt to counteract the mass of information in favor of State Medicine. The address is available to all debating societies, especially in our schools. The paper is to be printed, and may be secured at A. M. A. Headquarters later.

N. J. HEALTH AND SANITARY ASSOCIATION

The Secretary, Dr. A. Urbanski, read a letter from Dr. Kler inviting all members of the Middlesex County Medical Society to attend the 62nd annual meeting of the New Jersey Health and Sanitary Association at the Woodrow Wilson Hotel, New Brunswick, on November 20th-21st, 1936, at 10 a. m. (See Journal, December, p. 724.)

The Secretary read a letter from A. M. A. requesting rating of the new Roosevelt Tuberculosis Hospital.

RELATIONS UNDER THE FEDERAL SECURITY ACT

The following resolutions, formulated at a special meeting of the *Middlesex County Medical Society* held at the Perth Amboy General Hospital at 4 p. m. November 16th, 1936, were unanimously adopted at this meeting:

"The *Middlesex County Medical Society* is opposed to the establishment in Middlesex County of any new clinics, infant welfare stations, maternal welfare stations, or venereal disease clinics; or, the employment of a physician in infant welfare stations already existing which, up to the present time, have not had a physician in attendance. None of the physicians of the Middlesex County Medical Society will accept positions in any new clinics which may be established in Middlesex County; or in infant welfare stations, maternal welfare stations or venereal disease clinics; or accept employment in infant welfare stations already existing which, up to the present time, have not had a physician in attendance.

"Although we (the members of the Middlesex County Medical Society) believe that we are at present rendering adequate medical attention to the indigent and low-wage earning individuals in Middlesex County under present conditions of the practice of medicine existing in Middlesex County, we wish to present the following plan in concrete form to be used in Middlesex County for the medical care of the indigent and low-wage earning individuals:

"*First*: It is our belief that the best medical care is rendered in *doctors' private offices*, not in clinics. The lay public, health officers, nurses, and social workers must be taught that this is so. It is understood that all infant welfare, prenatal and maternal welfare, and venereal disease patients must be, in all instances, referred to the family physician who takes care of them either as private, relief, or indigent patients.

"*Second: For those indigents on municipal relief rolls in practically every community in Middlesex County* the so-called Middlesex Plan, which existed under the State E. R. A., is being used to render medical relief to relief clients. This system has proven highly satisfactory to both the patient and the doctor. We, therefore, believe that it should continue. Under this plan, the patient is entitled to free choice of physician, and the physician renders the same type of medical service as given to his regular private patients. However, this plan does not take care of a patient suffering from venereal disease. We are of the opinion that venereal diseases should be handled under a similar plan, and shall endeavor to make the necessary arrangements with local Boards of Health, or with Municipal Relief Agencies for the care of these cases.

"*Third: The Low-Wage Earning Individuals.* We believe that at present this group is receiving good and adequate medical attention, and that our present method of handling this group should be continued. That is, the individual patient goes to the physician of his choice, and is treated by the individual doctor privately, and receives the same type of medical care as the individual of better financial

status. He then pays the physician his usual fee, if he is able to; but, if he is unable to pay the fee, the doctor, at his own discretion, either treats the patient free of charge, or he may make an individual agreement, satisfactory to both patient and physician, as to how the patient will pay for medical service rendered. This, in the past, has proven highly satisfactory, and we believe that it will continue to do so. It is believed that all preventive medicine, mentioned under the Social Security Act for infant and maternal welfare and venereal disease, can be included under this plan.

"Fourth: Low-paid W. P. A., etc., workers who were formerly relief clients and are at present receiving all their income from public funds. We believe that the Middlesex County Medical Society should make an agreement with the individual Municipal Relief Agencies, whereby these agencies would render supplemental medical relief to these indigents under the same plan as is being used in giving relief to the regular relief client, so that the physician may receive some compensation for taking care of this group which, in most circumstance, they are now treating without recompense. Infant, prenatal and maternal welfare, and venereal disease control can be taken care of under this plan.

"Fifth: Immunization Against Diphtheria and Vaccination Against Smallpox for the Indigent and Low-Wage Earning Groups. We believe that the present *Public Health Hour* plan in the doctors' offices should be continued."

NEW MEMBERS

Dr. H. J. White was elected to full membership on a transfer from Union County. Drs. E. M. Walters and Cyril Hutner were elected Associate Members. Dr. Alexander M. Carr, Bonhampton, was elected to membership.

On motion, the meeting adjourned.

The annual dinner and meeting of the *Middlesex County Medical Society* was held December 16th, 1936, at "The Pines". The President, John J. Mann, called the meeting to order at 6:45 p. m.

GUEST SPEAKER

Mr. Winthrop D. Lane, Director of Division of Parole, Department of Institutions and Agencies, our guest speaker, gave a very interesting address on "Causes of Crime and Pertinent Facts on Parole". The address was discussed by Drs. Molitch, McGovern, and McKiernan.

PUBLIC HEALTH COMMITTEE

Dr. London, chairman, stated that every member must give their aid towards making a success of the Public Health Hour. He feels that the local Boards of Health and Education are justified in attempting to reach the indigent patient in the public schools in helping to "put across" this Public Health Hour. The State committee is preparing a manual outlining minimum office routine procedures which will be mailed to each member.

E. R. A.

Dr. Fithian, chairman, stated since the E. R. A. was dissolved there was nothing much to report. He thinks eventually the W. P. A. workers will be back on the E. R. A. rolls, and that the next legislature will have to provide for them by reopening the E. R. A. At this time provisions should be made to include orphans, widows, old age, etc., on the E. R. A.

CLINICS

Dr. Robert L. McKiernan, New Brunswick, read the following comments on the resolutions which were passed at the meeting of the society on November 18:

"Paragraph one reads, 'The best medical care is being rendered in dotors' private offices.' How many physicians are equipped to do spinal taps and their attendant laboratory work, so essential at some stage in the treatment of all syphilis cases? How many can do cardiographs on cardiac cases, or blood sugar tests for diabetes? With indigent maternity cases, will the physician also be willing to treat all of the complications which may arise, such as syphilis, diabetes, etc.? Where will he deliver his case? At home, with no skilled assistance? I doubt very much if any hospital will be willing to do any of the above mentioned tests, or admit for delivery maternity cases that have been carried in doctors' offices, even if they have been carried as free or part pay cases. Have arrangements been made with any of the hospitals for this work?

"Paragraph two states that the physician would receive free medicine for venereal disease cases, providing the patient could pay no more than $2.00 per treatment. There is no such thing as *free* medication, unless it is furnished by manufacturers for advertising purposes. If it is supplied by the State Department of Health, then it is paid for out of the taxes we all pay. Who will take care of the many cases who can not pay the $2.00 fee? I do not believe the local Boards of Health in some of our small communities could possibly pay $2.00 per treatment for their venereal cases, especially those acute cases needing more than one treatment a week; and still less pay for all their other indigent sick. Some of us have the class of patient who might not care to occupy the same waiting rooms with these cases; and if the physician has certain hours for the free cases alone, isn't he then conducting a clinic? Again, I say, few physicians are equipped to do a really scientific and complete piece of work in their offices on all cases.

"Under the third paragraph you condone clinics for the immunization of diphtheria and vaccination against smallpox. Why? Isn't syphilis as much to be dreaded as either of these? Isn't our infant mortality rate still pretty high?

"Do not think from my foregoing remarks I am in favor of the indiscriminate or wholesale establishment of clinics. I am not; but I do feel the indigent sick can be better cared for, from the standpoint of scientific medicine, in a few well-organized clinics. Personally, I would rather use several hours a week treating cases, where I have full equip-

ment, trained assistance and consultation facilities at hand, than to bother with them in my office.

"The fact I am in charge of the venereal disease clinic conducted at Middlesex Hospital and partly supported by the County of Middlesex, has no influence on my attitude. If I considered only the money angle, than I migh well say, 'No clinics', for I could enjoy a nice income if I received $2.00 and State medicine for every case I treated in the venereal disease clinic.

"It is well also to remember there are some of us who limit our practices to certain branches of medicine exclusively, and therefore deny ourselves access to some sources of revenue enjoyed by a large percentage of the profession, to wit: compensation cases and insurance and accident work which falls outside their special field. I still maintain, too, all physicians are not trained to treat all cases."

This communication was laid on the table for further consideration at the next meeting.

ELECTION OF OFFICERS

The following officers were elected for the coming year:

President, John H. Rowland, M.D.
Vice-President, J. V. Smith, M.D.
Secretary, J. F. Sandella, M.D.
Treasurer, Marshall Smith, M.D.
Reporter, Charles H. Calvin, M.D.

Two Delegates to the State Society (for three years):
R. L. McKiernan, M.D.
J. J. Mann, M.D.

Two Alternates to the State Society:
William H. McCormick, M.D.
Joseph Gutowski, M.D.

One Delegate to the Nominating Committee, State Society:
J. J. Mann, M.D.

One Alternate Member, Nominating Committee, State Society:
Henry Haywood, M.D.

The Treasurer, Marshall Smith, gave the following annual report:

Balance on hand December 15, 1935		$ 339.80
Deposits for year 1936		3065.50
		$3405.30
Expenses for year 1936:		
Disbursements to State Society	$1716.00	
Postage	95.26	
Printing	269.08	
Annual Banquet	137.55	
Refund	2.00	
Office Supplies	18.20	
Secretary ($15 per week)	552.50	
Bank charge	.40	
		2790.99
Reserve Fund		$ 614.31

The Treasurer reported on members in arrears.

DUES

On motion of Dr. M. Smith and seconded by Dr. M. Jacobson, the annual dues for members was raised to $25,00, and that of associate member to $18.00 yearly. This was passed favorably.

QUORUM

Dr. McKiernan showed that, according to Section seven of the Constitution, the quorum should be increased proportionately to the membership. This matter was laid on the table for the next regular meeting.

ADDRESS OF DR. J. J. MANN, RETIRING PRESIDENT

Dr. J. J. Mann, retiring President, gave an address, in which he reviewed the activities of the society during the past year. (This address is printed on page 44.—*Editor's note.*)

INTRODUCTION OF PRESIDENT ROWLAND

Dr. Mann then introduced the in-coming President, Dr. John H. Rowland, New Brunswick, who said that he would expect the aid and support of each member, for the society could not operate efficiently without this coöperation.

The following committees have been appointed by President John H. Rowland, M.D.:

Ethics Committee

Barth M. Howley, Chairman
R. J. Faulkingham — Ira T. Spencer
Martin S. Meinzer — Charles J. Sullivan

Committee on Credentials

Charles H. Calvin, Chairman
Henry A. Belafsky — Anthony J. Pellicane
George W. Paschal, Jr.

On motion, the meeting adjourned.

MONMOUTH COUNTY

O. R. Holters, M.D., Reporter

EXECUTIVE COMMITTEE

A meeting of the Executive Committee of the *Monmouth County Medical Society* was held at Fitkin Hospital on December 7th, 1936, with Dr. Walter Rullman, President, presiding. Members present were James Fisher, William Herrman, Harold Kazman, Daniel Featherston, Walter Gosling, Byron Blaisdell and O. R. Holters. Problems pertaining to the society were discusseed, including medical defense, and the appointment of committees on maternal welfare, mental hygiene, child welfare, tuberculosis, venereal diseases, and cancer. These committees are to work in conjunction with the State Committees covering these specialties.

SURVEY OF INDIGENT SICK

A committee consisting of Drs. Fisher, Herrman and Featherston was designated to consider the matter of engaging the services of an experienced secretary and investigator to assist the society in making a survey of the indigent sick in Monmouth County.

HOSPITAL STAFF CONFERENCE

On Wednesday evening, December 9th, 1936, the regular Staff Conference of the *Monmouth Memorial Hospital* was held at Long Branch, with a very large attendance. The usual analysis of the hospital work of the previous month was presented.

Dr. Victor Knapp, of Asbury Park, read a paper on the statistical study of the cases of diabetic gangrene of the lower extremity for the past five years in the hospital. The paper was discussed by Drs. Slocum, Altschul, Ransohoff, Kazman, and others.

COUNTY SOCIETY MEETING

On Wednesday evening, December 16th, 1936, the *Monmouth County Medical Society* held its regular meeting at the Berkeley-Carteret Hotel in Asbury Park, one week earlier than usual. The President, Dr. Walter Rullman, of Red Bank, presided with an unusual large attendance of members.

NEW MEMBERS

The following doctors were admitted to full membership, namely: Dr. Max Silverstein, of Asbury Park; Dr. Anthony Perrotta, of Red Bank; Dr. S. Thomas Miller, of Asbury Park.

SCIENTIFIC

The paper of the evening was given by Dr. Wright of the Post-Graduate Hospital of New York, entitled "Peripheral Vascular Diseases of the Extremities", which was illustrated by lantern slides.

The paper was widely discussed by those present.

STAFF MEETING

The regular monthly meeting of the Staff of the *Fitkin Memorial Hospital of Neptune* was held at the hospital Monday evening, December 21st, 1936. The meeting was presided over by Dr. James Fisher, chairman.

A letter was read by Dr. K. G. Brown, Secretary, from the American College of Surgeons, commending the hospital for its excellent rating.

A paper was read by Dr. Chait on the "Surgical Complications Attending Diabetes". A low mortality of only 11 per cent was quoted from the hospital records over a period of many years. The paper was discussed by Drs. Parry and Altschul.

Dr. Altschul also gave a short talk on pulmonary tuberculosis as a complication of diabetes, and quoted the susceptibility of the disease to tuberculosis. He also discussed the use of *protamine* in the treatment of diabetes.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A meeting of the *Morris County Medical Society* was held the evening of Thursday, December 17, at the Spring Brook Country Club in Morristown. President Sherman presided over an attendance of upward of 100 members and guests.

OFFICIAL VISIT

Dr. William G. Herrman, President-Elect of The Medical Society of New Jersey, gave an address on "The Program of the State Society", illustrated with lantern slides. Dr. Herrman described the "President's Cabinet", which consists of the associate officers of the State Society, for the purpose of representing the President in his many engagements. It also puts each officer at work, and thereby gives him experience in executive duties before he is advanced to the presidency. Dr. Herrman said that the time had passed when the presidency of the society was bestowed as a reward of honor for past service; and that now it is a call to deliver future service more active and original than ever before.

EXPLORER'S LECTURE

The entertainment feature of the meeting was by Amory H. Waite, Jr., radio operator of Admiral Byrd's "Ice Party" in Little America, and one of the three men who, after many setbacks and difficulties, finally reached Admiral Byrd in his tiny, isolated shack 123 miles south of the established base of the party, after his lone vigil of five months under the snows of the Antarctic winter night. With an intimate word picture supplemented by lantern slides of the expedition, the whole situation from even the preparatory stage to the finish was portrayed in a manner that gripped the audience, at times in tragic silence and again in lighter vein, as the audience listened to first-hand information from one who was actually on the scene with full participation in many of its most important incidents, all of which defies a second-hand description.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

A combined meeting of the physicians and pharmacists of Passaic County was held at the Alexander Hamilton Hotel, Paterson, N. J., on Thursday, December 10, 1936, at 9 p. m., as guests of the *Passaic County Pharmaceutical Society.*

RELATIONS OF PHYSICIANS TO PHARMACISTS

Dr. Spencer T. Snedecor, President of The Medical Society of New Jersey, was the first speaker. He gave an excellent talk on the plans of the Medical Society for meeting the mutual problems of the physicians and pharmacists. He spoke of the splendid work being done by the Council on Pharmaceutical Problems of the State Society.

ADDRESS OF DR. ULMER

The next speaker was Dr. Chester I. Ulmer, Chairman of the Council on Pharmaceutical Problems of the State Medical Society. He spoke first on the inauguration of the Joint Committee of Physicians and Pharmacists, who met two weeks ago at Trenton for the first time.

Dr. Ulmer next took up specific problems which confront the pharmacist, among them the following:

Patients asking questions about a prescription, such as, "What is it for?" "Is the doctor who wrote it a good one?"

Doctors writing prescriptions for proprietary articles which the patient reads and later calls for.

Patients using a sample of a proprietary drug given by the doctor, and later calling for more.

Counter prescribing.

The doctor dispensing medicines.

These and other problems were ably discussed by Dr. Ulmer, who was himself a pharmacist.

ADDRESS OF DR. MARQUIER

The last speaker of the evening was Dr. Adolph F. Marquier, Professor of Pharmacy at the Rutgers College of Pharmacy. He gave an excellent talk on seasonal remedies. He made a plea for the wider use of Pharmacopeial and National Formulary prescriptions, and showed how the cost to the patient came down immediately when doctors prescribed, instead of simply using, proprietary remedies. He showed that nearly all patented proprietary remedies were based on Pharmacopeial prescriptions with minor modifications.

Refreshments were served and a social hour was enjoyed by all.

It was felt by all that this meeting marked the beginning of an era of coöperation between the two professions; and the hope was expressed that more meetings of the same type be held in the future.

SALEM COUNTY

L. C. Hummel, M.D., Reporter

The regular meeting of the *Salem County Medical Society* was held Friday evening, December 11th, at the Salem Hospital. In spite of the inclement weather there was a good attendance.

COMMITTEEMEN

Dr. W. T. Hilliard and Dr. L. C. Hummel were appointed a committee on cancer control as a part of the program of public relations.

Dr. C. B. Mackes and Dr. W. S. Davison were appointed as a committee to arrange courses for graduate education.

ADDRESS BY VICE-PRESIDENT CARRINGTON

Dr. W. J. Carrington, First Vice-President of The Medical Society of New Jersey and ex-officio a member of the President's Cabinet, spoke on the program of the State Society, which has five major objectives:

1. To find the place of the medical profession under the new regimé of social security.
2. To secure better care of the indigent.
3. To improve hospital relationships.
4. To improve relationships between physician and public.
5. Wider diffusion of interest of all doctors in the State in problems confronting the profession.

Dr. Carrington stressed the fact that during the next few years the profession is going to be, more than ever, under the observing eye of the people trying to institute socialized medicine. Therefore, we must put forth every effort to show them we are able to take care of our problems without outside regulation.

SCIENTIFIC

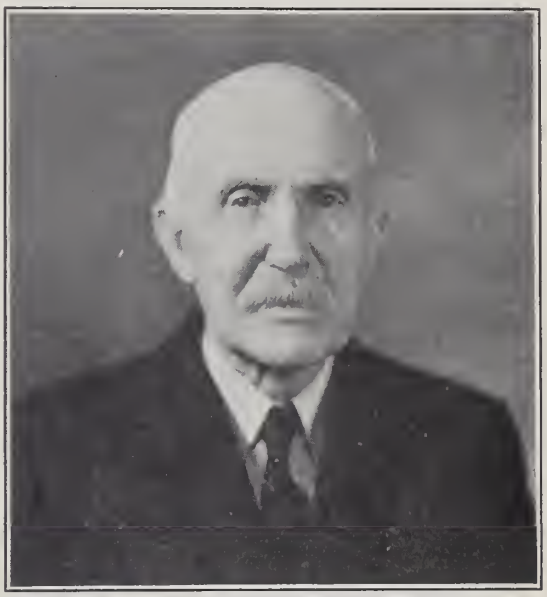
Dr. T. K. Lewis, of Camden, N. J., gave a very interesting and instructive talk on cardiac irregularities. He first reviewed the normal anatomy and physiology of the heart, and then discussed paroxysmal tachycardia, auricular flutter, extra systoles, and auricular fibrillation. He emphasized the value of a careful history and examination, and warned us that too many times we become lazy and depend on mechanical diagnosis.

A general discussion followed the paper, and many interesting cases were reported.

HONORING DR. SUMMERILL

A resolution was adopted requesting the State Journal to print an article on the life of Dr. J. M. Summerill, of Pennsgrove, N. J. He and Dr. Edward J. Ill, of Newark, are deans of the Medical Profession of New Jersey, both having been in continuous practice since 1875, the year of their graduation in medicine.

Born in Pennsgrove, New Jersey, August 27, 1851. Educated in the Pennsgrove Public Schools, Pennsgrove, and in Benjamin Russell's Private School, Pennsgrove; attended the West Chester academy and later Taylor and Jackson's Academy in Wilmington, Delaware.



DR. JOHN MORRIS SUMMERILL
Pennsgrove, N. J.

Medical Training.—Studied medicine under a preceptor, Dr. Mayhew Johnson, Pennsgrove, New Jersey, for two years, 1871 and 1872. Began studying at University of Pennsylvania in 1872, and graduated as Doctor of Medicine on March 12, 1875.

Began practice on May 10, 1875, at Woodstown, New Jersey. Practiced there until the fall of 1879, when he moved to Pennsgrove, New Jersey, where he has practiced ever since.

Civic Activities.—Physician at Salem County House 1876-1877. Member of the Board of Directors at City National Bank, Salem, New Jersey, since 1889, and is now the oldest living director.

Medcial Societies.—Joined Gloucester County Medical Society in 1876; and transferred into Salem

County Medical Society in 1880. Is a member of New Jersey State Medical Society and American Medical Association.

Married Eleanor Wagner Jacoby on November 6, 1895, and has two children: 1, Dr. Garnett Summerill (Rutgers University 1918, and University of Pennsylvania 1923), who is police and fire surgeon in the City of Camden, New Jersey; and also on the surgical staff at Cooper Hospital, Camden, New Jersey. 2, John Morris Summerill, Jr., lawyer, attended Rutgers University 1922, admitted to New Jersey Bar in 1926. He is Republican State Committeeman from Salem County, a member of the Board of Directors of City National Bank, Salem, and was Assemblyman from Salem County for 1930 and 1931.

UNION COUNTY

C. C. Carpenter, M.D., Reporter

The members of the *Union County Medical Society* were fortunate in having Dr. Spencer T. Snedecor, President of the New Jersey State Medical Society, give a clear, inspiring interpretation of the plans of the State Society for the coming year. Dr. Snedecor was the principal speaker at the last regular meeting, which was held at the Elizabeth General Hospital, Elizabeth, on December 9, 1936, with our President, Dr. Elmer P. Weigel, presiding.

PUBLIC HEALTH COMMITTEE

Under the regular order of business, Dr. Weigel read a list of members of the County Society whom he had appointed as advisers to its Public Health Committee. Dr. Burritt reported for this committee that its members had met with the Freeholders of the County, and that a sum of money had been appropriated to carry on the Mantoux testing of the freshman high school students. He suggested that the Public Health Committee be empowered to appoint members to the clinics for maternal health, tuberculosis control, baby keep-well stations, and venereal disease control. These members are to be paid from the Social Security funds for this purpose. This suggestion was approved.

MEDICAL-DENTAL SERVICE BUREAU

Dr. Schlichter has found that our members are not supporting the Medical-Dental Service Bureau as well as the members of the Essex and Passaic County Societies. He stressed the fact that if 50 per cent of the members would use this bureau, it could be made a success. The fees from all types of illnesses may be brought to its consideration, and not alone those that result from a surgical procedure.

GRADUATE COURSES

A communication from Dr. Satchwell, bringing to our attention a wider scope of post-graduate instruction that has been made possible by Social Security grants, was read to the members by Dr. Weigel. He appointed Dr. H. A. Abel as a committee to communicate with Dr. Satchwell, and report on how our members could get the most out of this instruction.

CANDIDATE FOR VICE-PRESIDENT OF THE STATE SOCIETY

On the motion of Dr. Edward Krans, the society voted to instruct its delegates to the Annual Meeting of The Medical Society of New Jersey on April 27, to present Dr. Watson B. Morris, of Springfield, as a candidate for the office of Second Vice-President of the State Society.

NUMBER OF MEETINGS

The desire of the society to continue with our present method of holding four meetings a year rather than change to a plan to have the meetings monthly from October to May was indicated by a refusal to change the Constitution. The proponents of the monthly meetings felt it would increase the regular attendance by having shorter business sessions, and more time to devote to scientific sessions and informal gatherings.

NEW MEMBERS

New members elected were:

Dr. Max S. Black, of Linden.
Dr. Edward E. Feleppa, of Summit.
Dr. Fletcher Gilpin, of Cranford.
Dr. Edward Kuchlewski, of Elizabeth.
Dr. Ernest I. Kyle, of Plainfield.
Dr. Rubin Poleshuck, of Hillside.
Dr. George McD. Relyea, of Summit.
Dr. Fred F. Senerchia, of Elizabeth.
Dr. Albert I. Whitken, of Elizabeth.

SCIENTIFIC

During the remainder of the evening, Dr. M. B. Radding, of Elizabeth, presented the case histories of patients on whom splendid end results had been achieved by radiological treatment. One was a Schüller-Christian disease, and the other a supposedly radio-resistant carcinoma of the larynx.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

A special meeting of the *Warren County Medical Society* was held in the rooms of the Fellow Craft Club, Washington, N. J., December 8, at 3:30 p. m. The meeting was called to order by the President, Dr. William Varney, of Washington; with twenty-four members and guests present.

PROGRAM OF THE STATE SOCIETY

Dr. E. Z. Hawkes, of Newark, Second Vice-President of the State Medical Society, spoke at some length on the program of the State Society.

Dr. LeRoy A. Wilkes, Executive Officer of the State Medical Society, elaborated on Dr. Hawkes' remarks on the State program for the care of the indigent; adding that the principle of socialized medicine as practiced in Europe would not be applicable in the United States with its varied medical and health problems in many states.

SCIENTIFIC

Dr. Donald Richards, Chief of the Obstetrical Department of Easton Hospital, read a very interesting paper on obstetrical anaesthesia.

NEW MEMBER

Dr. N. C. Marlatt, of Belvidere, was elected to membership in the society.

COMMITTEES

Dr. Varney then appointed the chairmen of the following committees: Dr. E. Krausz, of Cancer Control; Dr. H. B. Bossard, Tuberculosis Control; Dr. J. Weres, Maternal Welfare; Dr. H. Baldauf, Mental Hygiene; Dr. R. Buchanan, Crippled Children; Dr. H. Shimer, Venereal Diseases; Dr. L. Bloom, Child Health; Dr. F. Curtis, Public Health.

Dr. G. W. Cummings and Dr. Charles Lyons were appointed as a committee on Medical Defense.

HOSPITAL PERMIT

The application of Dr. J. Weres, of Alpha, to conduct a hospital of one bed was received and favorably acted on.

BABY KEEP-WELL STATIONS

The following members were recommended for supervision of Child Keep-Well Stations: Phillipsburg, Drs. L. Bloom, P. Drake, R. Buchanan; Washington, Dr. William Skinner; Alpha, Dr. J. Weres; Hackettstown, Dr. W. Harmon.

GRADUATE INSTRUCTION

It was moved and seconded that the matter of post-graduate courses be taken up with the State Society.

Meeting adjourned.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE BIOLOGICALS SINCE JULY 1, 1936

DIPHTHERIA TOXOID

County	To Nov. 30	Month of Dec.	Total to Dec. 31	Average per Month
Atlantic	179	4	183	30.5
Bergen	684	211	895	149.1
Burlington	118	38	156	26.
Camden	256	184	440	73.3
Cape May	32	9	41	6.8
Cumberland	230	5	235	39.1
Essex	6806	873	7679	1279.8
Gloucester	88	51	139	23.1
Hudson	73	31	104	17.3
Hunterdon	23	0	23	3.8
Mercer	28	4	32	5.3
Middlesex	833	74	907	151.1
Monmouth	310	126	436	72.6
Morris	102	35	137	22.8
Ocean	15	112	127	21.1
Passaic	1020	280	1300	216.6
Salem	39	4	43	7.1
Somerset	1520	11	1531	255.1
Sussex	24	41	65	10.8
Union	623	140	763	127.1
Warren	44	305	349	58.1
Totals	13047	2538	15585	2597.5

SMALLPOX VACCINE

County	To Nov. 30	Month of Dec.	Total to Dec. 31	Average per Month
Atlantic	317	104	421	70.1
Bergen	746	73	819	136.5
Burlington	216	1	217	36.1
Camden	449	7	456	76.
Cape May	54	3	57	9.5
Cumberland	268	13	281	46.8
Essex	2853	424	3277	546.1
Gloucester	278	22	300	50.
Hudson	64	2	66	11.
Hunterdon	21	0	21	3.5
Mercer	64	8	72	12.
Middlesex	505	33	538	89.6
Monmouth	517	846	1363	227.1
Morris	589	115	704	117.3
Ocean	97	7	104	17.3
Passaic	1667	73	1740	290.
Salem	25	0	25	4.1
Somerset	33	6	39	6.5
Sussex	122	0	122	20.3
Union	840	99	939	156.5
Warren	198	326	524	87.3
Totals	9923	2162	12085	2014.1

LIST OF PHYSICIANS DYING IN NEW JERSEY IN NOVEMBER, 1936

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Winfred E. Baldwin	71	Nov. 29, 1936	St. Vincent's Hosp.	Montclair	Diabetes.
John Cohen	44	Jan. 24, 1936	Mt. Sinai Hosp.	High Bridge	Carcinoma of the colon.
Mary J. Coon	73	Nov. 29, 1936	State Hosp., Parsippany	Same	Empyema.
Harry S. Doriss	68	Nov. 18, 1936	Northfield	Pleasantville	Cardio-renal disease.
Samuel B. Leyenberger	57	Nov. 4, 1936	Newark	Same	Coronary thrombosis.
Walter G. Mead	61	Nov. 2, 1936	Kearny	Same	Angina pectoris.
Thomas H. Rockwell	71	Nov. 2, 1936	Fair Oaks San.	Summit	Uremia.
Arthur Stern	68	Nov. 28, 1936	Elizabeth	Same	Coronary occlusion.
Adelbert A. Taylor	68	Nov. 1, 1936	Atlantic City	Same	Hypostatic pneumonia.
Eugene Way	79	Nov. 15, 1936	Margate	Same	Carcinoma of cecum.
Joseph E. Wright	74	Nov. 5, 1936	Westfield	Same	Angina pectoris.

OBITUARIES

DR. CHARLES F. ADAMS

Dr. Charles F. Adams, aged seventy-seven years, for many years one of the most prominent physicians of Trenton, died at his home on December 14th, 1936, after a brief illness. He was born in Bridgeton, July 5, 1859, and graduated from the Philadelphia College of Pharmacy and the Jefferson Medical College. Most of his years of practice were spent in Trenton. He was a prominent specialist in diseases of the eye, ear, nose and thoat, and was on the staff of the Mercer Hospital from the time of its organization. He was a Fellow of the American College of Surgeons, and a member of the Ophthalmological and Otolaryngological Society of Philadelphia, and an active member of the Mercer County Medical Society, The Medical Society of New Jersey, and the American Medical Association.

The esteem in which Dr. Adams was held not only by his medical colleagues but also by the people of Trenton, is indicated by the following editorial in the Trenton Times of December 15:

"Dr. Charles F. Adams, whose death took place yesterday, was a member of the medical profession who commended the respect and confidence of his fellow practitioners and also of many other citizens of Trenton who had come to know him either in a professional or a personal way during his long life here as a physician and citizen. Dr. Adams was a Trentonian who exemplified the finest ideals of citizenship, ideals which were given tangible expression during the war through his service in the Medical Corps and which were reflected in his active interest in all that pertained to the welfare of his city and of humanity. The last surviving member of the original staff of Mercer Hospital, Dr. Adams will be missed by that institution, also by the members of his profession and the city in general."

DR. DUNCAN CAMPBELL

Dr. Duncan Campbell, of Woodbury, died on October 30, 1936, from cerebral hemorrhage, aged 69 years. He was born in Caledonia, N. Y., graduated from Princeton University in 1892, and from Hahnemann Medical College, Philadelphia, in 1895. He practiced in Woodbury during the rest of his life. He was a Past President of the Gloucester County Medical Society and a regular attendant at its meetings. He was active in civic affairs, especially the Boy Scouts and the Rotary Club.

DR. SAMUEL F. ASHCRAFT

Dr. Samuel F. Ashcraft was the son of Dr. John H. Ashcraft, of Mullica Hill, Gloucester County, and took over his father's practice. He graduated from Jefferson Medical School in 1889, and served an interneship in Cooper Hospital, Camden.

Beloved by his patients, of sterling character and devoted to his duties and art, it may be said that he truly exemplified the "Country Doctor".

For many years a member of the Gloucester County Medical Society, he at one time filled the office of President, and was always a loyal and faithful member.

DR. H. WILSON STOUT

Dr. H. Wilson Stout, a practicing physician specializing in ophthalmology, died in his home in Wenonah, on June 29, 1936, of coronary disease after a short illness. He was born in 1890 in Wenonah, where he spent most of his years of practice since his graduation from the University of Pennsylvania in 1917. He was active in the Eye Department of the Cooper Hospital, Camden, and in the Underwood Hospital, Woodbury.

BOOK REVIEW

EXAMINATION OF THE PATIENT AND SYMPTOMATIC DIAGNOSIS, by John Watts Murray, M.D. Second Edition, 1219 pages, 274 illustrations. C. V. Mosby Co., St. Louis, 1936.

This book is essentially an index of differential diagnosis. It is divided into two parts. The first 430 pages include an introduction to methods of history taking and a listing of symptoms in general, as, for instance, pain, headache, dizziness, posture, nails, eyes, etc. Under each symptom or organ is a list of leading questions and associated with each question is a list of diseases which may be associated with an affirmative answer. For example, under "eyes" there are forty-eight questions, starting as follows: (1) Are the eyelids puffy? (2) Are there dark semi-circles under the eyes? (3) Has the patient a black eye? Etc. The diseases associated with an affirmative answer to question 3 are: injury, straining, fracture of base of skull, infantile scurvy, epilepsy, scurvy, infective endocarditis, hemophilia, etc.

The second section of the book lists in order the diseases of single organs or systems. Each system is introduced by a general discussion of method of examination and important points to be stressed in taking of history of that particular system. For instance, under the digestive system there is first an outline of questions to be asked about occupation and habits, eating, temperament, family history, taste, etc. Then follows a series of questions about physical examination, as: (1) Is the region of the stomach distended? (23) Does the navel protrude?, the answer to 23 being: hernia, ascitis, pregnancy.

The book is complete and has been brought up to date. It is primarily useful for the general practitioner and stresses the value of history taking and physical examination. Where a diagnosis cannot be made without laboratory aid, the appropriate laboratory procedure is mentioned.

This index, or one of its type, should be included in every physician's library.

MANFRED KRAEMER.

THE WOMAN'S AUXILIARY

Atlantic County

Reported by Mrs. L. M. Walker

Mrs. Raymond A. Williams entertained members of the Executive Board of the *Atlantic County Medical Auxiliary* at her home, Swarthmore and Atlantic Avenues, on Monday afternoon, December 14.

The regular monthly meeting of the group took place Friday, December 11th, at the Hotel Ambassador, when Dr. Norman Quinn spoke on "Health of Our School Children". Tea was served at the conclusion of the session.

Present were Mrs. Daniel Reyner, Mrs. Ruffin Stamps, Mrs. V. Earl Johnson, Mrs. Robert Kilduffe, Mrs. David B. Allman, Mrs. Morton Major, Mrs. Lawrence Wilson, Mrs. Percy C. Joy, Mrs. Raymond Williams, Mrs. L. M. Walker.

The regular monthly meeting of the *Altantic County Medical Auxiliary* was held on Friday, December 18th, 1936, at the Ambassador Hotel. At this time $10.00 each was voted to the following local charities and institutions for Christmas gifts: Pine Rest Sanatorium, Red Cross of Pleasantville, Betty Bacharach Home, Visiting Nurses, Atlantic City Welfare, and Atlantic City Day Nursery.

Due to illness, Dr. Quinn was unable to speak before the Auxiliary, but Dr. Charles Hyman, who is associated with him in his school work, gave a very interesting talk on the subject "Health of Our School Children". Due to recent publicity in our local papers about the inadequacy of health facilities for the school children, this was certainly a very timely discussion. It was voted at the close of the meeting to bring this matter to the attention of the various Parent-Teacher Associations.

Attending were Mrs. David B. Allman, Mrs. I. R. Beir, Mrs. E. H. Dyer, Mrs. Louis Feinstein, Mrs. E. H. Harvey, Mrs. William W. Hersohn, Mrs. Charles Hyman, Mrs. Percy Joy, Mrs. A. Kretchmer, Mrs. Morton Major, Mrs. James H. Mason, 3d; Mrs. A. G. Merendino, Mrs. M. J. Mally, Mrs. A. Rieck, Mrs. Daniel C. Reyner, Mrs. G. R. Stamps, Mrs. Samuel Salasin, Mrs. Harry Subin, Mrs. L. M. Walker, Mrs. Lawrence Wilson.

The next Executive Board meeting will be held at the home of Mrs. L. M. Walker. This precedes the regular monthly meeting of the Atlantic County Auxiliary, which will be held at the Ambassador Hotel on Friday, January 15th. Dr. Robert A. Kilduffe will be guest speaker of the evening.

Burlington County

Reported by Mrs. Roscius I. Downs

A luncheon meeting was held on Tuesday, December 1st, at Riverton Country Club. Mrs. D. H. LeFavor, of Palmyra, presided. Mrs. J. H. Horberger, of Roebling, Program Chairman, introduced the speakers.

Mrs. George Rogers, State President, of Newark, presented a review of the history of the Auxiliary, with a plea for us to carry on according to tradition. She presented a splendid slogan, "Talk less—accomplish more".

Mrs. A. Haines Lippincott, of Camden, State Chairman of Public Relations, stressed the idea of a Speakers' Bureau in order that organizations and clubs can be supplied with the best available speakers on health subjects. She especially recommended speakers on the subject of cancer, having recently attended the Cancer Clinic in Philadelphia. She entertained us with a description of a tour of the Pasteur Institute in Paris this past summer.

At a short business meeting following the speakers, we voted to give money to the Burlington County Hospital for Christmas donations.

We also contributed a wheel chair for children to the newly opened Zurbrugg Memorial Hospital in Riverside.

The members were conducted on a tour of the Zurbrugg Hospital on Friday, December 4th, and were tremendously impressed with it.

Following is a list of members present: Mrs. M. M. Schisler, of Florence; Mrs. William Bray, of Pemberton; Mrs. Lyman B. Hollingshead, of Pemberton; Mrs. J. H. Hornberger, of Roebling; Mrs. E. V. Davis, of Vincentown; Mrs. Harry B. Mark, of Riverton; Mrs. E. R. Mulford, of Burlington; Mrs. Howard Curtis, Mrs. Joseph Stokes, Mrs. Nathan Thorne, Mrs. S. H. B. Ulmer, Mrs. George Wilkinson, of Moorestown; Mrs. Walter Zurick, Mrs. Russell B. Geary, Mrs. Roscius I. Downs, of Riverside; Mrs. R. E. Haldeman, Mrs. Joseph Kuder, Mrs. G. E. McDonnell, Mrs. Daniel F. Remer, of Mt. Holly; Mrs. H. P. Landis, Mrs. Dean H. LeFavor, of Palmyra.

Essex County

Reported by Mrs. Frank S. Forte

The *Woman's Auxiliary to the Essex County Medical Society* held a board meeting at 12:30 p.m., and a business meeting at 2 p.m., on November 26th, 1936. It was voted to send honorary membership cards to three new women physicians.

At 3 p.m., the hospital and mission work in Labrador under the direction of Sir Wilfred Grenfell was told by Miss Eleanor Cushman. This lecture was open to the public.

Gloucester County

Reported by Mrs. Fuller Sherman

On Wednesday, December 16th, the *Woman's Auxiliary to the Gloucester County Medical Society* was entertained at a Christmas party at the home of Mrs. B. A. Livengood in Swedesboro. After a musical program and exchange of Christmas gifts, refreshments were served by the following committee: Mrs. B. A. Livengood, Mrs. William Crain, Mrs. William Pedrick, Mrs. H. W. Wright, Mrs. J. A. Stewart and Mrs. Fred Wandall.

A business meeting was held Thursday evening, December 17th, at 9 p.m., at the Homestead Coffee Shop. The President, Mrs. Don Weems, presided. Following the meeting, the social committee, Mrs. William Brewer and Mrs. Charles Pedrick, took charge. Later the members joined the doctors for supper.

Hudson County

Reported by Mrs. G. L. Murray

The *Woman's Auxiliary to the Medial Society of Hudson County* held its monthly meeting on Monday, November 2, 1936, at the Y. W. C. A. in Jersey City, Mrs. A. E. Jaffin presiding.

Mrs. Miles T. Long, Membership Chairman, reported that there were thirty-six members present. She also introduced two new members, Mrs. Cornelius P. McCarthy, of Bayonne, and Mrs. Edward N. Bookrajian, of North Bergen.

Mrs. Friele, Library Chairman, reported that two new books had been added to the library, one by Warwick Deeping and one by Lloyd Douglas. She urged the members to take advantage of our new "Lending Library".

Mrs. Abraham Schulman was appointed Chairman of a card party for the benefit of the "Entre Nous", our county paper. It was decided to have the party at the Y. W. C. A. on November 18th.

The meeting then adjourned, and an interesting talk on "Intelligence Tests" was given by Dr. Meta Anderson, Director of Special Education in Newark.

Dr. Anderson explained that the object of these tests is to determine the intelligence of an individual in order that he may be trained to use what intelligence he has to the fullest extent. She emphasized the fact that these tests are purely academic and that intelligence is only one part of us. She added, "Is it the most important part?"

She went on to say that because a child does not measure up to these tests does not prove that he will be a failure in life. Many failures in school are successful in industry, she stated. And she pointed out that 65 per cent of the people employed in Newark are employed in industry. She suggested that our educational system be adapted to the needs of the child.

A social hour followed and tea was served by a group of hostesses with Mrs. John Connell as chairman.

A Christmas party was held by the *Auxiliary to the Hudson County Medical Society* on Monday, December 7th, at the Y. W. C. A. in Jersey City at 2 p.m. It took the place of the regular December meeting, and over seventy-five members and guests attended the affair. The club room was beautifully decorated with pine and holly and candles, and a fire crackled merrily in the large fireplace. We are greatly indebted to Mrs. Peter Maras and Mrs. Louis Dodson, who had charge of these lovely decorations.

Mrs. A. E. Jaffin, our President, welcomed the large gathering and then turned the party over to Mrs Arthur Largay, who had charge of the program.

The program opened with group singing of Christmas carols led by Mrs. Warren Duckett with Mrs. Harry Perlberg at the piano.

Mrs. Largay then introduced Mr. Richard Blondell, a W.O.R. radio artist popularly known as "The Story Teller". Mr. Blondell read two very charming stories, "The Christmas Apple", by Ruth Sawyer, and "The Very First", by Stephen Southall.

We were next entertained by Miss Ruth Kelley, the very talented daughter of Mrs. Charles B. Kelley, one of our most active members. Miss Kelley is a violinist of unusual ability, and has studied both here and abroad. She played two very delightful groups of selections. The two groups contained such beautiful selections as "Sonata in E Major" by Handel, "Second Movement (adagio) from Violin Concerto in B Major" by Hadyn, "Landler" by Mozart, D Major "Sonatina" by Fauconier and "Cavatina" by Bohm. Miss Kelley was accompanied on the piano by Miss Jean Whitlock.

Between the two groups of violin selections there was more group singing, and then tea was served by Mrs. William Friele and a group of hostesses. While tea was being served, Felix Restivo, an accordianist, wandered here and there about the room singing and playing. Madame Phyllis De Rosa, an operatic soprano, who was a guest of one of our members, was persuaded to sing several Italian street songs, accompanied by Felix and his accordian.

It was a very gay party and a most enjoyable time was had by everyone present.

Mercer County

Reported by Mrs. L. L. Friedman

The *Woman's Auxiliary to the Mercer County Medical Society* held its first regular meeting at St. Francis Hospital on November 17th, Mrs. C. Chester Chianese presiding.

Surgical dressings were made throughout the day and tea was served at four o'clock by the Sisters.

Mrs. Frank A. McGuigan was in charge of arrangements for the session.

Dr. LeRoy A. Wilkes, of Pennington, N. J., was our guest speaker. His subject was "An Important Phase of Medical Practice". His talk was most interesting and dealt with symptoms and normalcy of adults and children.

Our first meeting was well attended by over fifty members.

The *Woman's Auxiliary to the Mercer County Medical Society* held an elaborate card party at the home of Mrs. John B. Sill on Monday evening, November 23rd. Over 200 members and friends were present. The affair was a great success both socially and financially. It was the first time that so many members were assembled at one time. Refreshments were served by the committee after the games. Fifty tables were in play.

An Executive Committee meeting was held at the home of Mrs. Alton S. Fell on Wednesday afternoon, December 9th. The meeting was in charge of our President, Mrs. C. Chester Chianese. Plans were made and dates set for our coming meetings. Our work done since September was summarized. It was passed that a part of the money realized from the card party should be donated to the five city hospitals toward Christmas cheer for the patients. A pleasant hour followed the meeting and tea was served by the hostess.

Much interest and activity is being shown by all our members this year, and we hope to keep on doing splendid work.



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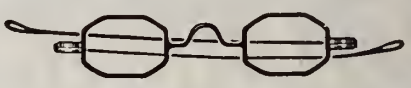
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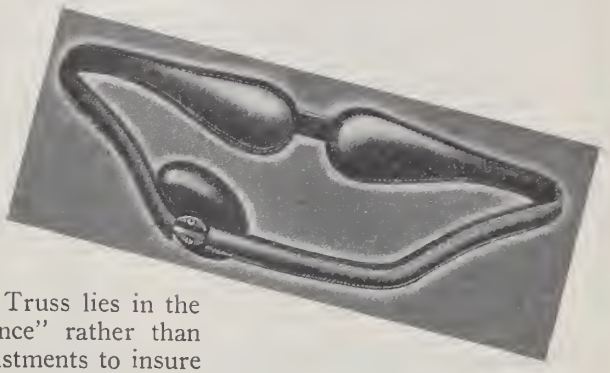
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*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923



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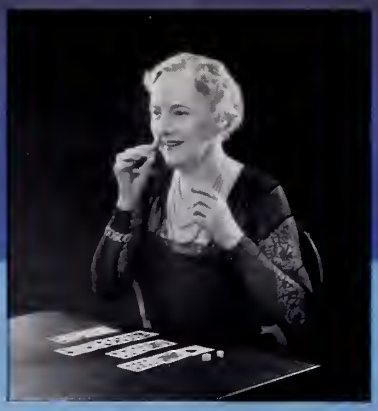
ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

BENZEDRINE INHALER

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

EST. SKF 1841

In Sinusitis



···BETWEEN OFFICE TREATMENTS

In acute and chronic sinusitis, the maintenance of maximal aeration and adequate drainage *between office treatments* often presents a problem difficult to physician and patient alike.

The use of liquid vasoconstrictors applied by spray or dropper during social activities or business is accompanied by obvious disadvantages. Benzedrine Inhaler, however, can be used inconspicuously at any time and in any place. Its convenience of application goes far toward insuring the comfort and co-operation of your patients.

Being volatile, Benzedrine penetrates to areas not readily accessible to liquid inhalants, promptly reducing engorgement wherever it exists in the rhinological tract. And, by re-establishing drainage of the accessory sinuses, it may often help to prevent acute attacks from becoming chronic.

Prolonged use of the inhaler does not tend to produce tolerance or atony.

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.—EST. 1841

CASE HISTORY: T. A. Male, white, age 27. Acute exacerbation of a chronic sinus infection.

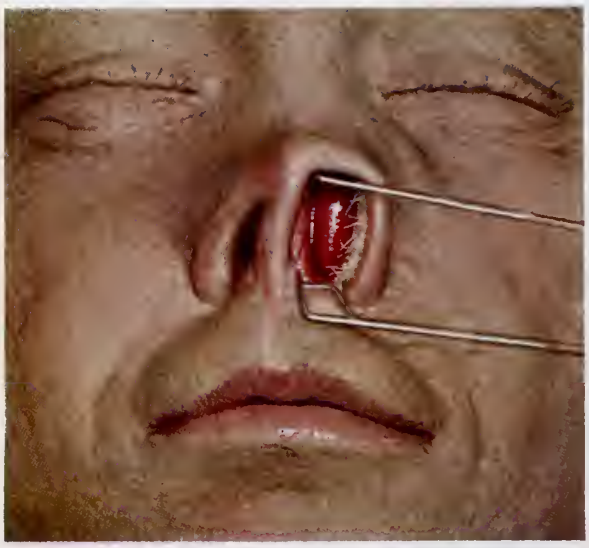


FIG. 1. 2:35 P.M. Before treatment.



FIG. 2. 2:57 P.M. After using Benzedrine Inhaler. Drainage established.

BENZEDRINE INHALER

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

Printed in U. S. A.

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★ *Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245*
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3, 306-309

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★ Reprint of papers from
N. Y. State Jour. Med. 1935, 35— No. 11, 590; Laryngoscope 1935 XLV, 149-154. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245. ☐

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CONSERVATION OF ESSENTIAL ELEMENTS IN PROTECTIVE FOODS

II. THE VITAMINS

● Refinement of vitamin assay methods has made practical many quantitative studies which had hitherto been impossible. Employment of these methods has yielded evidence which indicates that many factors may influence the vitamin content of foods which come to the table; in particular, the fruits and vegetables. Variety, maturity, time and temperature of storage after harvesting, and method of preparation, all have been found to affect the ultimate vitamin content of common foods. Several examples of the extent to which certain of these factors operate might well be given.

It has been shown that spinach slowly loses its vitamin C potency even in low temperature storage; at room temperature, one-half of the vitamin C is lost in three days; practically all antiscorbutic potency disappears in seven days (1).

Another report indicates a loss in vitamin C of 78 per cent in spinach stored two days at room temperature and 80 per cent loss in asparagus tips during four days' storage (2).

The vitamin C content of apples is markedly reduced during cold storage: 20 per cent in 4 to 6 months and about 40 per cent in 8 to 10 months (3).

Vitamin A in apples is, however, subject to less destruction than vitamin C during prolonged storage (4).

Prolonged cold storage of pears may result in a loss in the vitamin A and vitamin C content of nearly 50 per cent (5).

Further, solution losses which may occur during cooking vary with the individual product and with the method used in cooking. From 40 to 48 per cent of vitamin C may be lost to the water in which peas are cooked (6).

Vitamin C losses in 12 different vegetables have been reported to vary from 12 per cent in asparagus to 80 per cent in white onions (7).

These data demonstrate the seriousness of solution losses of vitamin C. It is considered probable that other water soluble vitamins are affected in a similar way.

Thus, by the time fruits and vegetables spend some days in transit or storage before reaching the kitchen and are cooked by the usual home method, much of the original vitamin content may have been lost. Little can be done to prevent storage losses when fresh fruits and vegetables are not available from the home garden, but solution losses may in part be overcome by using the cooking water.

Fortunately, in the commercial canning procedure, products are harvested at the optimum stage of maturity and canned immediately, using only a limited quantity of water which is retained in the can. As a result, storage losses of the vitamins are reduced (8), and solution losses may be eliminated by the use of the liquid in which the food is canned.

AMERICAN CAN COMPANY

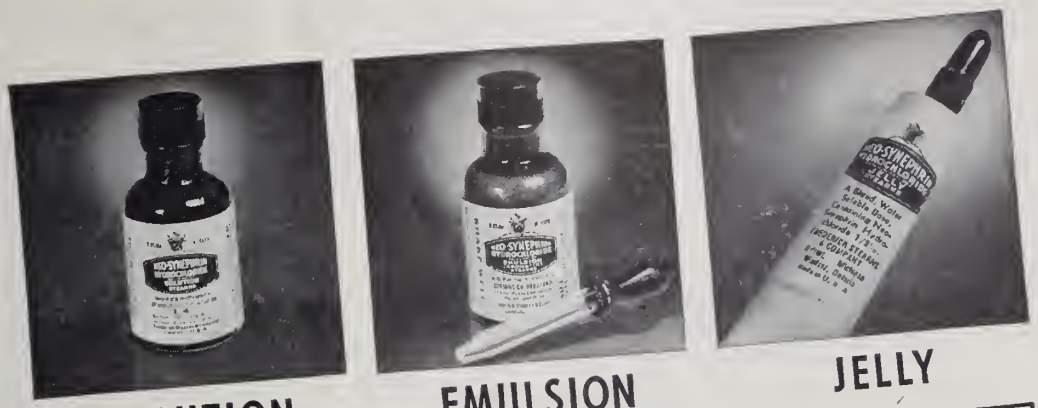
230 Park Avenue, New York City

(1) 1936. Food Research 1, 1.
(2) 1936. J. Soc. Chem. Ind. 55, 153T.
(3) 1933. J. Agr. Res. 46, 1039.
(4) 1936. Food Research 1, 121.
(5) 1934. J. Am. Diet. Assn. 10, 217.
(6) 1936. J. Nutrition 12, 285.
(7) 1936. J. Home Econ. 28, 15.
(8) a. 1921. Proc. Soc. Exp. Biol. Med. 18, 164
b. 1928. Ind. Eng. Chem. 20, 202
c. 1929. Ibid. 21, 347
d. 1932. J Home Econ. 24, 826

This is the twenty-first in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.



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Neo-Synephrin provides rapid and sustained control of the uncomfortable discharge associated with the common cold, sinusitis and other conditions of nasal mucosa engorgement.

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No sting
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Active on repeated administration
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FOR DIAGNOSIS:

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Bivalent Types I and II as well as Monovalent Antipneumococcic Serum, supplied in the following packages:

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Where normal sleep is difficult, the use of hypnotics or sedatives is often indicated.

Ipral Calcium (calcium ethylisopropylbarbiturate) is a safe sedative which induces a sound, restful sleep closely resembling the normal. It is rapidly and readily absorbed, effective in small dosage and rapidly excreted. No untoward organic or systemic effects have been reported from its use and undesirable cumulative effect may be avoided by proper regulation of the dosage.

Ipral Calcium is supplied in 2-gr. tablets and in powder form for use as a sedative and hypnotic.

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Tablets Ipral Aminopyrine (2 gr. Ipral, 2.33 gr. Aminopyrine Squibb) provide both analgesic and sedative effects.

Ipral Calcium (Powder) is available in 1-oz. bottles. Tablets Ipral Calcium, 2 gr., Tablets Ipral Aminopyrine 4.33 gr., Tablets Ipral Sodium, 2 gr. and 4 gr., and Capsules Ipral Sodium 2 gr. are available in bottles of 100 and 1000.

For literature write Professional Service Department, 745 Fifth Avenue, New York.



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The first formula must agree with the baby!

Newborns require breast milk. Deprived of human milk, their nutritional requirements are met by simple mixtures of cow's milk, sugar and water. The milk may be fresh, evaporated, dried, sweet or sour; the sugar simple or mixed.

Whole milk formulas are suitable for most newborns with good digestive capacities. **The amount of whole milk given should approximate ⅔ of the total required calories. And the remainder (⅓) should be in added Karo.** Water is added to the mixture for the fluid intake to be about 2½ ounces per pound of baby weight per day.

Evaporated milk formulas are indicated for newborns with limited digestive capacities. They may be used to advantage in considerably higher concentrations than whole milk for premature, feeble and debilitated infants. ***The added Karo is again one-third of the total required calories.***

Dried milk formulas are suitable for allergic infants who will take only small volumes at a feeding and for babies of allergic parents. Formulas approximately equivalent to whole milk may be made up with water and **Karo added in the same ratio as in whole milk mixtures.**

Acid milk formulas are of particular value for babies with low digestive capacities requiring large food requirements. Acid milk requires no dilution with water. **The amount of Karo required may be added directly** to the total volume of acid milk prescribed.

Karo is an excellent milk modifier of dextrins, maltose and dextrose (with a small percentage of sucrose added for flavor) for both the baby and the budget.

FORMULAS FOR THE NEWBORN

3 Ounces; 6 Feedings

Whole Milk	10 ounces
Boiled Water	10 ounces
Karo	2 tablespoons
Evaporated Milk	6 ounces
Boiled Water	12 ounces
Karo	2 tablespoons
Powdered Milk	5 tablespoons
Boiled Water	20 ounces
Karo	2 tablespoons
Lactic Acid Milk	12 ounces
Boiled Water	8 ounces
Karo	2 tablespoons

References: Kugelmass, Clinical Nutrition in Infancy and Childhood, Lippincott; Marriott, Infant Nutrition, Mosby; McClean & Fales, Scientific Feeding in Infancy, Lea & Febiger.

For further information, write Dept. SJ2
CORN PRODUCTS SALES COMPANY
17 Battery Place, New York, N. Y.



★ **Infant feeding practice is primarily the concern of the physician, therefore, Karo for infant feeding is advertised to the Medical Profession exclusively.**



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Five years ago Abbott and a cooperating laboratory offered Haliver Oil with Viosterol to the physician. It was born of original research at a time when much uncertainty surrounded the potency of many of the vitamin products on the market. Thereafter the physician could prescribe Abbott's Haliver Oil with complete assurance that his patients would get all those vitamins he intended them to have. And he did, after Abbott's ethical promotion presented him with the facts.

Today the story is unchanged. (Today, too, it is no secret that deficient vitamin products are still offered for sale.) Abbott goes direct to the source in the North Pacific and assumes complete control of production. No outside factor beclouds certainty of quality of our haliver products. After the fish are caught their freshly extracted livers are packed in ice and salt and rushed to our modern refinery in Seattle for preliminary assaying. Only fish oils of the highest quality are used.

Full vitamin potency is proved by rigid bioassays conducted in a fully equipped, completely modern laboratory under conditions making for the utmost scientific accuracy. All label claims for vitamin content are based solely upon the bioassay results, but as additional checks to accuracy, both colorimetric and spectroscopic assays are applied to each lot at Abbott Laboratorics.

Prescribe Abbott's Haliver Oil with Viosterol routinely for lactating or expectant mothers, and all other patients who require additional Vitamins A and D. Available at prescription pharmacies in soft, tasteless capsules in boxes of 25, 50, 100 and 250. They are also available in 10-cc. and 50-cc. vials with special droppers. Abbott Laboratories, North Chicago, Ill.



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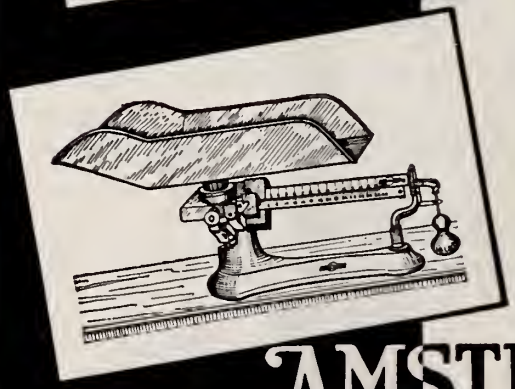
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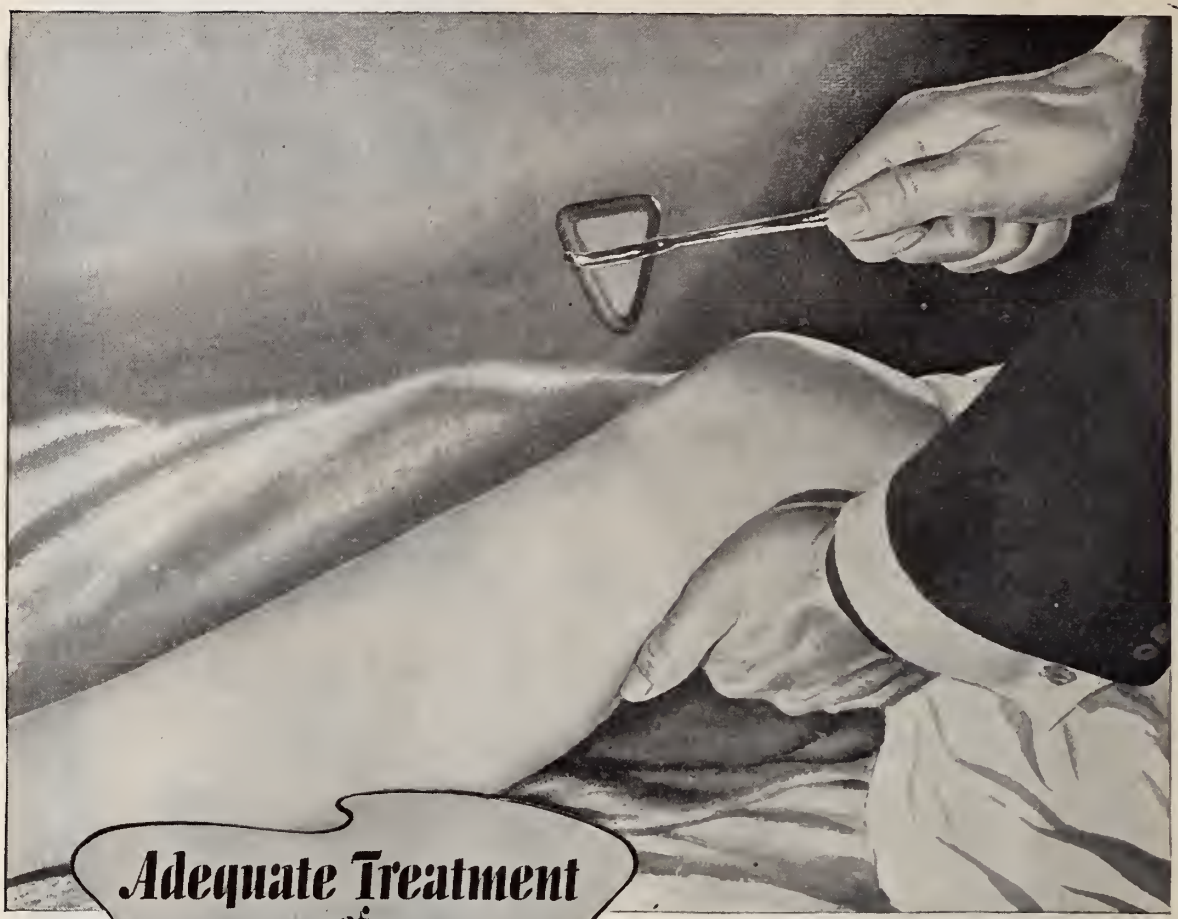
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Adequate Treatment of Pernicious Anemia

● Of paramount importance in the treatment of pernicious anemia is the administration of adequate antianemic material, such as is contained in liver, to restore hemoglobin and red blood cell levels.

In cases where there is evidence that subacute combined degeneration of the spinal cord is present, therapy must be adequate to arrest completely all progress of the cord degeneration. Adequate doses of solutions of liver extract can be conveniently given by parenteral injection.

For this purpose the following preparations are offered:

Solution Liver Extract Concentrated, Lilly—Supplied in 10-cc. rubber-stoppered ampoules and in packages of four 3-cc. rubber-stoppered ampoules.

Solution Liver Extract, Lilly—Supplied in 10-cc. rubber-stoppered ampoules.

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Volume XXXIV.
Number 2

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly

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Direction of the
Committee on Publication

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Executive Officer—LeRoy A. Wilkes, M.D.
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Vol. XXXIV, No. 2 February, 1937 Subscription, $3.00 per Year
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EDITORIALS

Practice in Public Health

The physicians of New Jersey are actuated by a sincere desire to give the people of the State the best medical service that it is practical for them to deliver, and for the people to accept and apply. Inspiration to extend efficient medical services more widely among the people is coming from two sources:

1. The Medical Societies of the Counties and the State.

2. The officials of the State and Federal Governments who are offering assistance along financial lines and social advice.

The normal evolution of methods to diffuse the benefits of medical practice to all the people would require years; but in this age of speed serious attempts are under way to accomplish this desirable objective in a few months. Every practicing physician in New Jersey is seriously affected by this nation-wide movement, and is personally concerned with its outcome.

The most serious problem which confronts the Medical Profession of New Jersey is that of securing the concerted action of every one of the four thousand doctors of the State in carrying out any definite plan of action. Two methods of securing this action are proposed:

1. The regimentation of a sufficient number of physicians under governmental direction and control, to insure the proposed services.

2. The voluntary action of every practicing physician to deliver his services more widely among that group of people to whom he is the Family Doctor.

It cannot be expected that the four thousand physicians of New Jersey will suddenly be inspired to adopt a uniform method of action; but they are organized in medical societies whose chosen leaders have studied all phases of the problem in consultation with government officials. These representatives have devised a practical plan of action based on the assumption that each individual practitioner of medicine will make a conscientious effort to deliver efficient services along the seven lines of maternal welfare, child health, venereal disease control, tuberculosis, mental hygiene, cancer control, and the treatment of crippled children. And in order to inform Family Doctors of the details of the plan, the Committee on Public Health has prepared and in the near future will issue a handbook of suggested procedures in each of the seven fields of practice.

Curative and Preventive Medicine

The practice of the healing art by educated physicians has been recognized as a public necessity since the dawn of history. The science and art of medicine has reached such a high degree of development that physicians now classify themselves according to a triple basis:

1. Scientific attainments.
2. Freedom of action.
3. Degree of sickness (or health) of their paticnts.

1. On the basis of their scientific attainments, physicians are classed as:

a. General practitioners.
b. Specialists.

About three-fourths of the physicians of New Jersey are general practitioners with stable clienteles who are proud of their "Family Doctors".

2. According to their freedom from control, physicians are divided into two classes:

a. Those in private practice.
b. Those in public health service.

The essential distinction between these two groups is in the manner of their engagements, —private practitioners being chosen and paid by the patients themselves; while those doing public health work are appointed and paid by a third party who is the intermediary between the doctors and the patients whom they treat.

3. According to the degree of sickness—or health—of their patients, physicians render two classes of service:

a. Curative.
b. Preventive.

The majority of the physicians of New Jersey are *Family Doctors,* who make their living by their *private practice* of *curative medicine.* Every physician also renders daily service in *public health,* by practicing some form of *preventive medicine* at the same time that his major service is along curative lines.

It is unfortunate that both the laity and the Medical Profession make clear-cut distinctions between *public health* procedures and *private practice,* and between *curative* and *preventive* services. All forms of medical service are evolutions of the methods in use when medical practice dealt almost entirely with diseases in their *fully developed forms.* The dominant characteristic of modern medical science is the discovery and application of methods of diagnosing and treating diseases *in their incipiency.* This evolution has been along two lines:

1. The establishment of laboratories—bacteriological, pathological, radiological—which are available to render service to every physician by methods which are entirely impersonal and scientific.

2. The accurate observation and evaluation of the clinical symptoms and signs which are characteristic of each disease or disorder of the human system; and their classification in medical journals and text-books which are available to every Family Doctor.

Every Family Doctor practices *preventive* medicine when he makes a correct diagnosis and institutes proper treatment early in a case of sickness.

Much praise has been justly bestowed on the diagnostic acumen of the skilled practitioner of former days whose sole basis of judgment was the information which he obtained through his five senses, without the aid of the clinical thermometer, or the stethoscope, or the microscope, or the x-ray laboratory. The modern physician is equally skilled in the use of his five senses, amplified and standardized by the instruments of precision which he always carries in his professional bag.

The best Family Doctor is he who is consciously aware of two groups of facts:

1. The pathological conditions that can produce the symptoms and signs which are within the range of his bedside observations, amplified by the information supplied by available laboratories.

2. The symptoms and signs to be elicited in order to confirm a tentative diagnosis which he will have in mind at the end of his first call.

The field of medical knowledge in which every physician is expected to be proficient has become so vast that the most practical and popular medical address at a county society meeting is that which lists the symptoms and signs of each of several related conditions. such as that of Dr. T. K. Lewis on heart arrythmias on page 101 of this Journal.

Addresses on Socialized Medicine

A year and a half ago, the subject of socialized medicine seemed likely to become an immediate issue of national policy. A system of high school debates was fostered by social security organizations, and some of them published handbooks containing arguments purporting to cover both the affirmative and the negative sides of the question. Many high schools of New Jersey appealed to the State Medical Society for information on the subject; but physicians had difficulty in separating *truth* from *propaganda*. In some places the representatives of the county medical societies secured permission to present the medical point of view to the audiences that assembled to hear the debates, but the medical speakers were usually introduced at a late hour when the people were ready to go home, and the practicing physicians were compelled to rest their argument on the mere statement of their opinion. Happily, their reputation for careful thinking and disinterested action had more weight than long arguments, and the threatened avalanche of laws establishing socialized medicine was averted.

We are now entering upon a second stage of a campaign of educating the people regarding socialized medicine, and there is need for the development of clear outlines of addresses on the subject, which may be delivered under the auspices of the Speakers' Bureau of the Committee on Public Relations.

Production and Salesmanship

A doctor's office is like a commercial store whose reputation and success depends on two factors:

1. Production—or the goods which are offered for sale.
2. Salesmanship—or delivering the service which the people want or need.

Many a store is well stocked with goods, but the service is lacking. The prospective customer receives scant attention, and is told that it does not carry the particular kind of article which the customer needs; or little attention is paid to him.

In another store the stock is small, but the storekeeper shows a keen interest in his customer's welfare. He diagnoses the customer's needs, and offers to get the desired article and deliver it to him promptly. He invites the customer to return and discuss the use to which he puts the goods. If the customer is dissatisfied, he seeks to discover the cause of his dissatisfaction, whether it is in the article itself, or the manner of his using it. The storekeeper not only seeks to make an immediate sale, but he also "Services" the goods. In other words, the store-keeper gives *personal service* as well as sells the goods. Such a store-keeper is bound to be successful even though his store is small and inconspicuous.

The stock which the physician carries is his *personal service*, although many of his patrons seem to think that it consists in the pills and potions which he dispenses. The successful physician gives his undivided personal attention to each patient, in order to ascertain his peculiar needs,—to make a correct diagnosis—so that the patient feels that his condition is thoroughly understood. The doctor is not content with a snap judgment, but confirms his opinion by scientific tests, and by a consultation with a more experienced diagnostician, if necessary. His patients stick by him because they feel that he understands them and is using every means at his command to give the relief or protection which is sought. If a cure is impossible, the physician will still endeavor to make the patient's condition endurable, so that he may live a contented life in spite of his physical handicap.

Every physician belongs to a great fraternity in whose benefits he is both a sharer and a contributor. His secrets are not wilfully hidden from anyone, but he is ready to share them with all those who have the knowledge

and mental capacity to understand them. He is eager to adopt the methods of his successful fellow practitioners, and to conform to the standard practices of his fraternity, one of which is to make an earnest endeavor to reach a correct diagnosis in each individual case, and to deliver the form of treatment which is approved by his brethren in the medical fraternity. While the successful Family Doctor must necessarily be individualistic in his contacts with his patients, yet he is guided by the collective opinions of his brethren based on their experiences under conditions similar to those which confront him. He is therefore an active member of his county society, and observes the methods of practice to which his fellow members subscribe.

The medical societies of the counties and the State of New Jersey are now engaged in developing methods of practice adapted to the conditions of modern society, of which the most essential is that every physician shall practice the highest method of medical service which is approved by his fraternity brethren.

The Current Year

During the current year the work of The Medical Society of New Jersey has developed steadily and logically in three natural steps:

First, the Society began the year with a definite program which had been developed by the President and his Cabinet, the Trustees, and the Welfare Committee. Definite projects had been outlined and their execution had been assigned to over twenty committees whose members had considered the welfare of the Society their own personal responsibility. Never before had there been such a unity of purpose and execution.

Second, the visitations of the members of the President's Cabinet have inspired the members of the county societies with their own enthusiasm and clearness of views. It has been the constant endeavor of the State officers to inform the members of their essential place in the state-wide plans regarding the delivery of medical service; and their intelligent response has been most gratifying, as is shown by the reports of the county societies reported in The Journal. What have been ideals have been transformed into local actions throughout the State.

Third, the time of accounting for the year's work is now at hand. No work is complete until its extent and value has been appraised, its items of progress enumerated, and a balance sheet drawn up, as will be done in the forthcoming annual reports to be presented to the Annual Meeting of the House of Delegates.

The annual reports will also be forward-looking, and each will state the outlines of the objectives which the new officers may consider.

The developments of the current year will be a sure foundation on which The Medical Society of New Jersey will grow to greater heights of influence and achievement.

Look for these illuminating reports in the April issue of The Journal.

Contacts and Approaches

The members of The Medical Society of New Jersey realize the complexity of the necessary elements which enter into the delivery of the varied services of medicine. No longer is the Family Doctor the sole worker in the field of medicine, dependent on the members of the families of the sick and their neighbors for the simplest services, such as nursing, and relief. The list of the helpers of every doctor has grown to such an immense extent that it includes organizations beginning with hospitals, and extending to Departments of Health and Welfare, and to voluntary health organizations, all formed to deliver the services which formerly were donated by the relatives and close friends of the sick. A community, large or small, is now one immense family in which the responsibility of the immediate

neighbors has been expanded to include the county, the State, and the nation.

The Family Doctor too has broadened his field of view, and now realizes the essential value of the services given by the allied groups.

In the evolution of the methods of the delivery of the services of medicine, there has naturally been evidences of narrow points of view in which each group has emphasized its own field of work. But in recent years the Medical Profession has made friendly approaches to its allied organizations, and has entered into agreements with them, especially in clearly defining their respective fields of action. An example of these broadened contacts is the Joint Conference of the New Jersey Hospital Association held in Newark on January 27, when the relations of the hospital to the doctors were presented from the point of view of the Medical Profession. Merely to state the respective field of action of hospital managers and the doctors on the medical staffs is of the greatest possible value in reaching amicable agreements.

The members of the county medical societies have also developed a broadened sense of their unity of purpose with that of the local lay organizations, as was shown by the prominent place assigned to representatives of The Medical Society of New Jersey on the program of the meeting of the New Jersey Health and Sanitary Association that was reported on page 724 of the December Journal. This is of the greater significance when one considers that most health officers of New Jersey are laymen, whose closest associations are naturally with the lay health organizations.

The results of the closer contacts is the recognition of the Medical Societies as the Family Doctors to the lay groups,—the State Society to the State-wide organizations; and the county society to the local groups. A list of sixty State-wide organizations to which The Medical Society of New Jersey is the logical medical adviser is printed on page 256 of The Journal of May, 1936. A similar list of the county organizations would fill several pages of The Journal.

The Speakers' Bureau

The basic organization of society of today is the *group*. When dealing with any basic principle now, we must deal in terms of the group. Medicine of today cannot be independent; and in the same spirit it is not dependent. Society today is complex. Its organization is similar to that of the human body. Each organ contributes its own function to the total function of that system of the body; and each system contributes its share in the total physiology of the body. In health, every system works in harmony with every other system. The systems are complementary,—one does not essentially depend on the other, but health does depend upon the harmonious interplay of all.

In this same way Medicine is an essential part of society. We need not fear our position if we realize our *social* responsibilities. A physician is still a citizen; and because of his peculiar place in our social order he is in a most strategic point to render service and still maintain his professional integrity.

Like the oracles of long ago, medicine has been silent. We still have the respect of the public, and can maintain the confidence of the public if we assume the full responsibility for the health care of everyone. Let us prepare ourselves for this responsibility. The ideal, we know, is the private practitioner's office. Every physician's office can be made a public health center if every physician will realize his public health opportunities and responsibilities. Only then can we succeed.

In dealing with the public at large we must deal as one group with another group. A friendly presentation of common problems permits solutions mutually advantageous. We must realize that the public is not trained professionally. People cannot know the technical problems of health care. We must, therefore, guide the public through this maze of health care problems. If we formulate their questions, our answers will be intelligent. With an understanding of problems and an apprecia-

tion of their solution, the public will not hesitate to entrust its welfare in our hands.

How can we accomplish our aim? Our goal can be attained with relative ease if we work in harmony. First we must define our purposes and formulate our plans; and then we shall need publicity,—the type of publicity that is authoritative and friendly, the type of publicity that draws followers. Your Public Relations Committee will soon complete a publicity program that should be effective. It includes a *State Speakers' Bureau,* a *Radio* Program and *Newspaper* articles on health. All speakers are prepared to speak with knowledge and authority. The radio program can reach the majority of homes. The newspaper articles, we hope, will meet a definite need. But to carry the message of medicine into every community needs the integration of the County Medical Society. Only with a County Speakers' Bureau can this be done. In order to present a correlated program your State Committee will furnish material for County Speakers. To succeed, cooperation and uniformity are essential.

This program in principle is not new, for it has been tried time over. Its novelty is in the attempted integration of every County Society, and the correlation of our activities. We must be vocal; but at the same time we must be accurate and uniform. In unity we shall have our greatest strength. In this strength we shall not only serve most, but will be better understood. It is understanding that we need most.

J. H. Kler.

Rights to Health

The Declaration of Independence names life, liberty, and the pursuit of happiness as three inalienable rights of mankind; but their interpretation has undergone a great evolution. These rights have a direct application to the practice of medicine, whose fundamental object is the preservation of the first right—that of *life*—in its efficiency and fullness.

In 1776 *liberty* in its relation to medicine was interpreted to mean that every person was responsible for his own life and health. Physicians were as individualistic as the people, and delivered their services to those persons only who sought their advice for actual sickness. Only about half the people had the inclination and the means to take full advantage of the services which Family Doctors could supply.

In recent years there has come the recognition of the principle that the *pursuit of happiness* by a large proportion of people requires community action in health matters, directed by physicians as an organized group; and still more recently the medical profession has taken effective steps to put that principle into active practice, as the Welfare Committee of The Medical Society of New Jersey is doing.

Let's Talk Facts

No government can insure your health; they can only *tax* the people to pay for the medical care furnished—often by politically controlled doctors and only to politically approved sick persons.

The term *Health Insurance* is an attractive wrapper under which to conceal a *tax* to support a political machine which will take as much as possible from the public, and give back as little as possible.

There is little financial profit in furnishing the best grade of medical services to all the people in need thereof—too many can not or will not pay for medical service.

Private insurance companies insure only selected healthy people who can and will take care of themselves and pay their bills. They exclude the costly "bad risks" from sickness benefits and these companies also count on the present high grade of medical care found in the U. S. A.—not the type available to those who pay the government taxes in those countries where "Health Insurance" is a political football.

L. A. W.

ORIGINAL ARTICLES

RECURRENT FUNCTIONAL HYPOGLYCEMIA IN JUVENILES

A REVIEW WITH PARTICULAR REFERENCE TO ITS CONVULSIVE MANIFESTATIONS

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From the Department of Pediatrics, Harvard Medical School, and the Children's and Infants' Hospital, Boston, Mass. Read before the Section on Pediatrics at the 170th Annual Meeting of The Medical Society of New Jersey in Atlantic City, June 4, 1936.

Since the genesis of simple methods for the determination of blood sugar, there have been many publications regarding the conditions in which hypoglycemia occurs. Most of these have been concerned with the hypoglycemia of adults, especially with that condition known as hyperinsulinism. However, there have been relatively few communications on the occurrence of hypoglycemia in children, and not a great deal of stress has been laid upon *convulsions* as an outstanding symptom of their defective sugar metabolism.

The association of convulsions with hypoglycemia was first pointed out by Josephs [1] in 1924. He described the case of a child with recurrent vomiting attacks, accompanied by convulsive seizures, in whom the blood sugar on such an occasion was found to be 37 mgm. A search of the literature for the past twelve years reveals that there have been reported thirty-five cases of convulsions in juveniles in whom hypoglycemia was, presumably, the sole etiological factor of importance. It is of significance to note that among this group,[1-14] the hypoglycemia which prevailed was apparently functional or spontaneous in thirty-two cases. Only three showed demonstrable organic lesions; one a case of multiple pancreatic adenomata with hyperinsulinism reported by Wolf,[7] another, a case of islet cell hyperplasia discussed by Dannenberg,[11a, b] and the third, an example of hepatic insufficiency incident to profound fatty degeneration, reported by Kramer.[10] In addition, one of the cases reported by Higgons [14] occurred in a newly born infant whose mother was a diabetic. The child recovered, hence this was probably a case of transient hypertrophy of the Islands of Langerhans.

At the Infants' and Children's Hospital, Boston, we have had an opportunity to observe ten cases of functional hypoglycemia of the recurrent type associated with convulsions. In seven of these, hypoglycemia was the only finding of significance. Two cases showed evidence of cortical atrophy that probably was contributory, although it might have been the result of the convulsions; and a third had cerebral edema which was thought to be secondary to a fulminating infection.

In the cases in our series, practically every child was subjected to an intradermal tuberculin test, Wassermann reaction, urinalysis, stool examination, and clinical blood counts. Roentgenograms were taken as indicated; and in several instances, special studies such as blood chemistry determinations and metabolic tests were carried out. In each case, a specific search for plumbism was made. All blood sugar determinations were made on capillary blood according to the micro technic of the Folin-Wu method. Dextrose tolerance was ascertained by the oral method, using a uniform dosage of 1.75 grams of dextrose per kilogram of body weight.

Because of the shortage of time, and the similarity of the cases, only two of the ten cases will be described. If time permits, we will present the diagnostic blood sugar levels, and the detailed dextrose tolerance curves later. (Tables 1 and 2.) Summaries of the remaining nine cases are appended.

Case 2. D. Cr. was a five-year-old boy of Canadian extraction, whose family and past histories were not unusual. He was first seen on November

14, 1932, with the complaint of recurrent convulsions.

At the age of eighteen months the child vomited, and had a generalized convulsion of thirty minutes' duration. Throughout the next six months he complained at irregular intervals of high abdominal pain. On one occasion this was accompanied by a "fainting spell". Four hours prior to admission to the hospital the patient awakened in the early morning complaining of abdominal pain. Vomiting ensued, and this was soon followed by tonic and clonic convulsions that lasted for thirty minutes.

Seen at the hospital three hours later, a well-developed but thin boy of five years was found in deep coma. The cheeks were flushed, and a poorly sustained vertical nystagmus was present. The only other finding of note was a marked pharyngeal injection, and a purulent post-nasal discharge. There was a large amount of acetone in the urine. Spinal fluid was normal except for a sugar estimated to be less than 25 mgm. by a rough quantitative method. The blood sugar was 40 mgm. and a final analysis of the spinal fluid sugar was found to be 20 mgm. The method used was as follows:

Place one c.c. of Benedict's reagent into each of five small test tubes, and number them from one to five respectively. To each tube, add a corresponding number of drops of spinal fluid (for example, tube number one will contain one drop, and tube number five will contain five drops) and boil in a water bath for ten minutes. Reduction normally begins in the third tube. If no reduction occurs in any of the tubes, the spinal fluid sugar may be estimated at less than 25 mgm.

After 200 c.c. of a 10 per cent solution of dextrose had been given intravenously, he became bright and talkative. During hospitalization, the patient ran an afebrile course. Convulsions and abdominal pain remained absent. Four days after admission, a dextrose tolerance curve was as follows, expressed in milligrams per cent: Fasting—88, 45 min.—143, 75 min.—120, 105 min.—123, 165 min.—118, and 225 min.—75.

During the next year, the course was uneventful except for one nocturnal attack of abdominal pain and vomiting followed by convulsions. After sweetened orange juice was finally given, he responded promptly. In November, 1933, dextrose tolerance was again determined, and showed: Fasting—77 mgm., 30 minutes—96, 60 minutes—116, 120 minutes—71, and 240 minutes—64 mgms. Five minims of subcutaneous epinephrine produced a rise of blood sugar to 90 mgm. after ten minutes, and to 100 mgm. after thirty minutes.

Case 5.—A. C., a two-and-one-half-year-old boy of Jewish parentage was brought to the hospital on June 2, 1932, because of convulsions for sixteen hours. The family and past histories were not unusual.

At the age of twenty months the child had his first convulsion after two days of diarrhea and mild fever. During the next ten months there were several attacks of a similar nature, usually associated with an acute infection. His present seizure was preceded by two days of semi-starvation incident to tonsillectomy.

Upon admission, an obese child of two and a half years was found in a generalized clonic convulsion. His temperature was 101° F., his breath was heavy with a sweet fruity odor, and the skin was flushed. The only other finding of note was an acute post-tonsillectomy pharyngitis. Acetonuria was excessive. Despite unusually heavy subcutaneous sedation, there was a persistance of convulsions during the next six hours. Lumbar puncture yielded a normal fluid, except for a spinal fluid sugar estimated to be less than 25 mgm. Because of this finding, he was given 10 per cent dextrose solution intravenously, and the convulsions ceased immediately. Six days later, the following dextrose tolerance curve was obtained: Fasting—111 mgm., 30 minutes—140, 60 minutes—127, 90 minutes—125, 120 minutes—122, and 180 minutes—108 milligrams per cent.

Upon discharge, parental advice included the administration of sweetened fluids at the onset of infections. During the ensuing sixteen months, there were no further convulsions in spite of frequent respiratory infections. A dextrose tolerance test at the end of that time was as follows: Fasting—95, 30 minutes—125, 60 minutes—123, 90 minutes—108, 120 minutes—97, and 180 minutes—123 mgm.

INCIDENCE

Spontaneous hypoglycemia of the recurrent type associated with convulsions may have its onset at any period throughout infancy and childhood, although the majority of cases are seen in the age group from one to three years. It is relatively infrequent under one year of age, and it is not common for the first attack to appear after the age of three.

Although our series is too small to render sex of any great importance, attention is called to the fact that eight of the eleven cases occurred in males. An analysis of the cases reported in the literature also shows a preponderance of males over females, with a ratio of two to one.

MECHANISM OF RECURRENT HYPOGLYCEMIA IN CHILDREN

Generally, the blood sugar is regulated through the activity of the pancreas, suprarenal, thyroid, and pituitary glands, as well as the liver. While dysfunction of any of these organs are theoretically capable of producing hypoglycemia, convulsions in infancy and childhood, in this series at least, it seems possible to exclude a number of them with fair ac-

curacy. Tumors of the pancreas with hyperinsulinism run a progressive course with practically no tendency toward spontaneous improvement or recovery. Only one case in children has been reported, and their extreme rarity under twelve years of age is well attested to by the fact that in 1500 consecutive autopsies performed at this clinic, there have been no gross nor microscopic evidences of pancreatic neoplasm.[15] Likewise, hypertrophy and hyperplasia of the islet cells are almost as infrequent, only one case having been reported after infancy.[11b]

Hyperinsulinism as a result of increased vagal activity cannot be definitely eliminated, but there have been no reported clinical evidences to indicate that such a condition exists. Therapeutic tests with atropine in hypoglycemia of the suspected vagatonic type have failed to substantiate this diagnosis.[16] Furthermore, the children in our series showed nothing suggestively vagatonic. Hypotrypsinism seems unlikely as stool examinations did not show any digestive impairment indicative of a trypsin deficiency. Evidences of apparent suprarenal insufficiency such as adynamia, apathy, and hypotension, were notably lacking, and there was nothing suggestive of hypothyroidism or pituitary dyscrasia.

Hepatic hypoglycemia appears to be a more feasible explanation of these juvenile cases. It has been established that fasting in children causes a rapid and profound exhaustion of glycogen reserves. The immature organism is unable to create a degree of compensation, by glycogenesis, to maintain a normal blood sugar level.[17-18] Rumpf has demonstrated that the carbohydrate reserves of newly born infants is exhausted in twenty-four hours, and he suggested that the ease with which this phenomenon occurs is directly proportional to the age.[19] Josephs has shown that children subject to hypoglycemia have a greater fall in the sugar level after fasting than do normal children.[2] It is not difficult to see how agents that increase body metabolism, such as overexertion or fever, could lead to a depletion of the carbohydrate reserves. This would be enhanced in the presence of an inadequate caloric intake induced by anorexia, vomiting, or short fasts. An analysis of the response to epinephrine in our series, even at a time when they were asymptomatic, suggests poor glycogen storage or difficulty in releasing the glycogen.

SYMPTOMATOLOGY

In adults, the list of symptoms referable to hypoglycemia is long, and is analagous to those observed in overdosage from insulin.

In children, a similar series of symptoms may occur, but as many of them are subjective, they are less frequently elicited. Prodromal symptoms include pallor, restlessness, irritability, hunger, anxiety, sweating, tremor, and epigastric discomfort. Vomiting often occurs; and if the attack continues, there is a final termination in tonic and clonic convulsions, and then coma. Drowsiness may be present, and often persists after the acute phase for several hours. This is probably due to an associated ketosis. Not infrequently, no history of prodromal symptoms can be obtained, and the first warning of impending danger is a generalized convulsion.

Physical examination shows very little. Objective findings include a sweet fruity odor to the breath, ketonuria, with an absence of glycosuria. Fever may or may not be present, depending upon the presence of an associated respiratory infection. Examination of the spinal fluid is negative, except for the very important finding of a diminished spinal fluid sugar.

RELATION OF GLYCEMIC LEVEL TO SYMPTOMS

There is no absolute blood sugar level at which hypoglycemia manifestations occur. This point shows great individual variation, and fluctuates in the same patient from day to day. The "habitual" blood sugar level is of great importance, and the final development of symptoms depends largely upon the rapidity with which the new low level is reached.[20]

This variation is well illustrated in a case reported by Derick et al.,[21] in which an extremely low hypoglycemic level of 25 mgm. was attained on one occasion without symptoms, while at other times, the patient would show marked evidence of hypoglycemia with

a much higher level. Weil [22] mentions a case with a blood sugar level ranging between 37 and 45 mgm. for many hours without discomfort. In contra-distinction, it has been shown that diabetics under insulin therapy may develop symptoms of insulin reactions with hyperglycemic levels of 150 mgms. or more; [23] and in non-diabetics, Pribam has found clinical hypoglycemia when blood sugar values of 80 to 90 mgm. were obtained.[24]

DIAGNOSIS

The diagnosis of convulsions associated with hypoglycemia may be suspected in those children in whom the attacks occur late at night, in the early morning, or several hours postprandially, with a preceding history of anorexia, fever, vomiting, excessive exercise, or excitement. There is nothing diagnostic about the character of the convulsions, and physical examination shows very little of significance, except for evidence of ketosis. A diminution of the spinal fluid sugar in an otherwise normal spinal fluid is a highly suggestive finding of great diagnostic value. For most practical purposes, spinal fluid sugar, in the absence of red cells, may be assumed to be one-half of the blood sugar.[25, 26] This low spinal fluid sugar value served as a diagnostic lead in several of our cases.

Final diagnosis rests upon the finding of a convulsive or post-convulsive blood sugar of less than 70 mgm. It should be stressed that glycemia readings obtained at other times are practically valueless. Spontaneous hypoglycemia of this type is intermittent, and between attacks, essentially normal sugar levels exist.

A dextrose tolerance test at the time of convulsions is impractical, and between attacks it is not of great diagnostic assistance, although there is some slight tendency toward an increased tolerance to carbohydrate in these cases. A combined analysis of the curves in this series, plus those reported in the literature on juvenile cases, shows an average maximal blood sugar rise of 48 mgm. The average "normal" maximal rise for children of this age is quoted as approximately 67 mgm.[27] Rather frequently, these cases also exhibit a tendency toward the approach of hypoglycemic levels at the end of three to four hours. Of suggestive importance is the finding of Dannenberg [11b] in his case, that the use of excessively large amounts of dextrose (four grams per kilogram of body weight) in the test meal, showed a marked increase in the dextrose tolerance, with a definitely hypoglycemic end value to the curve. Since his case was one of hypertrophy of the islet cells, this finding may more properly be indicative of a true hyperinsulinism, in contrast to functional hypoglycemia. However, the variation among normal children is so great, and the cases of our series demonstrated such individual variations, that one is hardly justified in considering them conclusive. Likewise, the response to epinephrine was somewhat less than is usually found, the average rise (maximal) in our series being 33 mgm. There was no correlation between the dextrose tolerance and adrenalin response.

It is obvious that other convulsive disorders in childhood, such as tetany, meningismus, organic involvement of the central nervous system, including lead encephalopathy, must be excluded by the appropriate diagnostic measures.

TREATMENT

The therapeutic procedure of choice during an attack is the immediate administration of *dextrose by phleboclysis*. For this purpose, a solution of 10 per cent strength, in quantities calculated at 10 c.c. per pound of body weight, has been found to be most effective. The total amount should not exceed 300 c.c., and administration must be done slowly to prevent diuresis, and subsequent loss of dextrose through the kidneys. This procedure may well be complemented with saline hypodermoclysis to combat any existing dehydration. Results are usually dramatic, with the prompt cessation of convulsions, and rapid recovery. Occasionally drowsiness persists for several hours. Should difficulties be encountered with the intravenous technic, a three to five per cent solution of dextrose by hypodermoclysis is useful.

Prophylactic treatment is largely dietary. Attacks are prevented in most cases by the use of a diet moderately high in carbohydrates, augmented by a mid-morning, a mid-afternoon,

and after-supper feeding. Such a regimen usually controls hypoglycemia of this type. There is a remote possibility that such a high carbohydrate intake would stimulate the islet cells, with an overproduction of insulin. Several adult cases have had their attacks aggravated by a high carbohydrate diet, but some of these were subsequently found to have tumors of the pancreas.[22, 28, 29, 30, 31]

Should an exaccerbation occur under such treatment, considerable clinical evidence has accrued to show that a mild ketogenic diet, such as a two-to-one ratio, is worthy of trial.[22, 32, 33] A dietary of this type would seem rational, since it has been demonstrated by Rumpf,[19] and by Kohn,[34] that it produced a moderate depression of carbohydrate tolerance, with an increased and protracted hyperglycemia. Thompson [35] also showed that an induced ammonium chloride acidosis increased hyperglycemia, with a diabetic type of dextrose tolerance curve, but with an absence of glycosuria.

The use of extracts of the pituitary, thyroid, and suprarenal glands as a therapeutic and prophylactic measure in adults has been advocated by several investigators, with results, that in general were unsatisfactory.[36, 37, 38, 39, 40] Their use in juvenile hypoglycemia does not seem indicated.

The possibility of pancreatic neoplasm in children, even though remote, should be kept in mind. If the course is progressive, and unaccompanied by demonstrable dietary benefit, exploratory laparotomy should be considered.

In cases of suspected hyperinsulinism without evidence of tumor, subtotal pancreatectomy has been performed, without clinical improvement in most cases.[41] This procedure does not seem justified in childhood.

Particular attention should be directed toward carbohydrate feedings at the onset of infections, as attacks are especially prone to occur at this time. Should the necessity for any surgical procedure arise in these hypoglycemic children, it is essential that their preoperative care should embrace the liberal use of dextrose solutions.

PROGNOSIS

As only a decade has elapsed since Josephs first called attention to this condition, and because of the small number of reported cases, the ultimate outcome of these children is not known. Although several cases in adults had their onset in the adolescent period, none of them extended back to childhood, and there exists no apparent relationship between the two. Case eight of our series had her initial convulsion when eight years old, and there was a complete cessation of attacks with the advent of menstruation. It would seem logical to assume that puberty, with its reorganized endocrine activity, would exert a beneficial effect upon functional hypoglycemia.

The outlook for the individual hypoglycemic attack is good. Under therapeusis, response is usually dramatic, and undoubtedly many recover from their convulsions without any treatment. Rabinovitch and Barden [42] have recorded one fatal case that failed to respond to intravenous dextrose. Case ten of our series went on to a lethal termination, but death was due to a fulminating streptococcal infection.

Grayzel [43] has shown experimentally that induced hypoglycemia with convulsions caused anatomical changes in the brain with permanent symptoms of central nervous system degeneration. Convulsions, per se, when frequent or severe, may produce cortical atrophy from an associated cerebral edema. Case seven of this series developed cortical atrophy, although it is possible that this was secondary to intracranial hemorrhage sustained at birth. Our series, otherwise, showed nothing indicative of neuropathological disturbance.

CASE REPORTS

Case 1.—D. C., a six-year-old boy of Irish parentage entered the Children's Hospital on May 15, 1933, because of recurrent convulsions for three years.

The family and past histories were not contributory, and his development had been normal.

The child had his first convulsion at three years of age, and during the ensuing years had four similar attacks of moderate severity. These seizures lasted from five to fifteen minutes, and were often followed by drowsiness. They were preceded by no apparent infection, and between convulsions his general health seemed excellent. The attacks were all nocturnal, with the exception of one, which

occurred in the late afternoon, after a day of hard play.

On the morning of entry, the child awakened and felt weak. Nausea soon developed, and after two emeses, he lapsed into a deep coma from which he could not be aroused.

Seen at the hospital four hours later, examination showed an afebrile, comatose boy of six years, who was slightly undernourished, but well developed. Except for a flushed moist skin, carious teeth, and a pharynx very moderately injected, his physical findings were not remarkable. There was an acetonuria without glycosuria present, and his blood sugar was 42 milligrams per cent.

The administration of 250 c.c. of a 10 per cent solution of dextrose by phleboclysis was immediately instituted. When approximately half of this amount had been introduced, he became responsive, and soon appeared quite normal and alert.

A dextrose tolerance curve performed two days later elicited the following results: Fasting—99 milligrams per cent, 30 minutes—167, 60 minutes—230, 150 minutes—140, and 210 minutes—67 milligrams per cent. On the following day, his fasting blood sugar was 77 milligrams per cent, five minims of epinephrine were then given subcutaneously and the following figures obtained: 15 minutes—88 milligrams, 30 minutes—114, 60 minutes—103 mg. (See Table 1.)

Examination showed a semi-comatose, obese girl of twenty-seven months, whose physical findings were remarkably negative. During the next few hours convulsions continued, unabated by sedatives in massive doses. A blood sugar taken several hours after admission was 57 mgm. Acetonuria was marked. Sweetened fluids were then given orally with rapid cessation of convulsive seizures, although drowsiness continued for eighteen hours. A dextrose tolerance curve, six days later, gave the following result: Fasting—78, 30 minutes—105, 60 minutes—133, 120 minutes—91, and 180 minutes—80 mgm. She was discharged under advice to be given sweetened fluids upon retiring. Her subsequent course could not be determined.

Case 4.—K. G. was a male infant of one year, first admitted on January 16, 1933. He had been born at term by internal podalic version, and breech extraction. There was moderate asphyxia, and cyanosis was noted for twenty-four hours. A lumbar puncture was negative. Subsequent development seemed normal in all respects.

At one year of age, after a slight injury, he refused food throughout most of a day, and seemed irritable. The following morning, two generalized convulsions occurred, and he was rushed to the hospital.

Physical examination disclosed an intensely in-

Case	1	2	3	4	5	6	7	8	9	10
Age	6 yr.	5 yr.	27 mo.	16 mo.	30 mo.	3 yr.	3 days	9 yr.	5 yr.	3 yr.
Blood sugar	42mg%	40mg%	57mg%	29mg%	.....	.....	36mg%	64mg%	66mg%	37mg%
Spinal fluid Sugar	.....	20mg%	.....	21mg%	25mg%*	25mg%*	17mg%	.....	.....	.....

TABLE 1.—Diagnostic Levels of the Cases in This Series

The patient remained in the hospital for seven days without further convulsions. He was discharged with instructions to drink sweetened fruit juice upon retiring, and at the onset of impending attacks.

Five months later the child was again seen; and in the interval there had been no further convulsions, despite an attack of bilateral parotitis. Dextrose tolerance at that time showed: Fasting—83 mgm., 30 minutes—106, 60 minutes—109, 90 minutes—89, 120 minutes—86, and 180 minutes—69 mgm. He was given five minims of epinephrine, with a rise in blood sugar to 81 mgm. in ten minutes, and to 97 mgm. after thirty minutes.

Case 3.—M. G., a female infant of twenty-seven months whose familial background, birth, and development had been uneventful. She was admitted to the Children's Hospital on August 8, 1933, because of convulsions for fourteen hours.

Five days before entry, after a long automobile trip without food, the child vomited, and complained of marked anorexia, abdominal pain, and became drowsy. Throughout the next few days these symptoms continued, and at times she was very restless and unresponsive. On the morning before admission, convulsions began and continued intermittently during the day.

flamed throat, and a temperature of 103° F. Spinal puncture was recorded as negative. Following sweetened fluids orally, there were no further convulsions, and he was discharged afebrile on the third day.

Four months later, the infant again developed a respiratory infection accompanied by anorexia, irritability, and vomiting. It terminated in a generalized convulsion, and after five hours of semiconsciousness, he was admitted to the Infants' Hospital.

Examination at that time showed a drowsy, rather unresponsive male infant of sixteen months. There was a sweet fruity odor to the breath, moderate dehydration, horizontal nystagmus, and an acutely inflamed throat. Spinal fluid was normal except for a spinal fluid sugar of 21 mgm. The blood sugar was 29 mgm. and the carbon-dioxide combining power was 33 volumes per cent. The urine contained large amounts of acetone. Following dextrose by phleboclysis, and a saline hypodermoclysis, rapid improvement was evident, and by the next day he appeared normal. A dextrose tolerance test two days later showed: Fasting—59 mgm., 30 minutes—108, 69 minutes—77, 120 minutes—83, and 180 minutes—69 mgm. After three minims of epinephrine, the blood sugar readings were: 15 minutes—100, 30 minutes—114, 45 minutes—118, and 120 min-

utes—95 mgm. He was discharged with instruction to take sweetened fluids at the onset of infections.

Four months later the following dextrose tolerance curve was obtained: Fasting—84 mgm., 30 minutes—89, 60 minutes—106, 90 minutes—110, 120 minutes—83, 180 minutes—78, 240 minutes—80, 300 minutes—77 mgm. Ten minutes after three minims of epinephrine, the blood sugar was 92, which in 30 minutes rose to 104 mgm.

During the next nine months he was kept on a high carbohydrate diet, but he often developed postprandial hunger, and on such occasions he would appear excited and irritable. Finally, after a day of little food and excessive exercise, convulsions began, and he was readmitted to the hospital for the fourth time on July 2, 1934.

Temperature was 101° F., and very little was to be found on examination other than pallor, dehydration, and coma. The blood sugar was 51 mg. After four minims of epinephrine, it rose to 69 in 15 minutes, and to 71 mgm. in 45 minutes, without apparent clinical improvement. Intravenous dextrose was equally futile, and convulsions continued intermittently for eight hours. On the third, and again on the seventh day, at which time he developed evidences of epidemic parotitis, convulsions recurred with blood sugar values ranging from 127 to 130 mgm. Spinal fluid was normal.

Case	1		2		3	4		5		8		11
Fasting	89	83	88	77	78	59	84	111	95	100	89	95
½ hour	167	106	143	96	105	108	89	140	125	200	127	170
1 hour	260	109	120	116	113	77	106	127	123	200	105	113
1½ hour		89	123				110	125	108		105	
2 hour		86		71	91	83	83	122	97	148	116	81
2½ hour	140		118									
3 hour	67	69			80	69	78	108	82	111	92	78
4 hour			75	64			80				79	
10 min. p. epineph.		81		90		100	92		130		79	
30 min. p. epineph.		97		100		114	104		123		95	
60 min. p. epineph.						116						

TABLE 2.—Dextrose Tolerance Curves and Epinephrine Response in Recurrent Hypoglycemia Between Attacks. (Values expressed in mg.%.)

An encephalogram later showed nothing abnormal. The boy was placed on a ketogenic diet having a ratio of three grams of fat to one gram of carbohydrate, and to date there has been no return of convulsions.

Case 6.—A. S. was a native born girl of three years, who was hospitalized November 7, 1931, because of coma for three hours. The family history was not relevant, and her birth and development had been uneventful except for pertussis at one year.

After three days of respiratory infection with anorexia and fever, the child was found in bed at 8 a. m. in deep coma, from which she could not be aroused.

On admission, examination showed a well-developed and nourished semicomatose female child of three years, whose breath had a sweet fruity odor. Other salient features were mild dehydration, diffuse pharyngeal injection, copious post-nasal discharge, and an absence of all deep reflexes. Urinalysis demonstrated large amounts of acetone without sugar. Because of finding a spinal fluid sugar estimated at less than 25 mgm., glycopenia was suspected, and dextrose in orange juice was given orally. Recovery was complete within three hours. On the third day of entry, after high carbohydrate feedings, her spinal fluid sugar had risen to 74 mgm. A fasting blood sugar two days later was 83.3 mgm.

She was discharged with the precautionary advice of taking sweetened fluids in the event of acute infections. During the next three years there were no further attacks.

Case 7.—T. M., a three-day-old male infant, was admitted to the Infants' Hospital on January 2, 1930, because of failure to nurse.

The infant was born at term by a normal vertex delivery after a difficult and prolonged labor. The immediate post-natal condition seemed good, but twenty-four hours later he failed to nurse. During the next forty-eight hours practically nothing was taken by mouth, and at the end of that time he became inactive and stuporous.

On examination, a moderately well-nourished male infant of three days was seen. He was semicomatose, and a sweet fruity odor could readily be detected on the breath. Except for generalized spasticity and hyperactive deep reflexes, examination was negative. The sugar content of the spinal fluid was reduced to 17 mgm. and the blood sugar was 36 mgm. Generalized convulsions began, and as there was a slight prolongation in the bleeding time, a small transfusion was given. This was followed by dextrose solution intravenously, with prompt cessation of the convulsions. Twenty-four hours later the blood sugar had risen to 114 mgm. After six days of gavage feedings, the infant began to nurse well. The spinal fluid was normal on discharge, and convulsions did not recur.

For a month steady progress was made, but after that convulsive twitchings, uncontrolled by a high carbohydrate intake, began. The baby seemed retarded mentally. At the age of four months, he was readmitted to the hospital for further study. Encephalograms disclosed a diffuse cortical atrophy, and the patient was subsequently institutionalized.

Case 8.—M. S., a nine-year-old girl of Irish ex-

traction, was first seen on June 16, 1931, on account of recurrent convulsions for six months. The familial background was of no moment, and her past history not eventful.

Six months prior to admission, while apparently in excellent health, the girl had two attacks characterized by generalized convulsions and loss of consciousness. Both of these attacks took place an hour after retiring. Two weeks later, a fasting blood sugar was found to be 80 mgm., and shortly thereafter a post-convulsive blood sugar of 70 mgm. was obtained. During the next three months she had approximately twenty convulsions. They were preceded by pallor, sweating, apprehension, restlessness and tremor. Almost invariably they were precipitated at 5 a.m. or 9:30 p.m. On another occasion, glycemic analysis shortly after a seizure was 64 mgm.

Admitted to the hospital for investigation, the physical examination was quite negative. Her Stanford intelligence rating exceeded 100 per cent. Encephalographic studies were likewise negative. During her stay, no convulsions occurred, and at the time of discharge the following dextrose tolerance curve was found: Fasting—100 mgm., 30 minutes—200, 60 minutes—200, 120 minutes—148, and 180 minutes—111 mgm.

During the next eighteen months, while on an average diet, she had thirty-six generalized convulsions. Early in 1933, however, they became less frequent, and when menstruation began shortly after that, her attacks ceased entirely. Seen in November, 1933, the girl had been asymptomatic for nine months, and a dextrose tolerance test then showed: Fasting—89 mgm., 30 minutes—127, 60 minutes—105, 90 minutes—105, 120 minutes—116, 180 minutes—92, 270 minutes—79 mgm. At that time she became restless and uneasy, with pallor, sweating and tremor; ten minims of epinephrine was given subcutaneously with the relief of all hypoglycemic manifestations within five minutes. Ten minutes later the blood sugar was 95 mgm.

Case 9.—H. M. was a five-year-old boy of Irish parentage who was brought to the Children's Hospital on April 10, 1933, following a convulsion. The family history was negative, and his birth and development had been normal.

On the day preceding admission, he ate very little breakfast and appeared flushed and irritable. No lunch was eaten, and that afternoon excessive perspiration was noted. At 5 p.m., while playing, he was found unconscious by a nelghbor. En route to the hospital convulsions began.

On arrival, the boy was in deep coma. He was well-nourished and developed, and no evidence of infection or abnormality could be noted. Acetonuria was present. There were no further convulsions, and after the oral administration of dextrose consciousness was rapidly regained. Twelve hours later, while asymptomatic, his blood sugar level was 66 mgm. Owing to a request for discharge, no further studies could be made.

Case 10.—R. B., a native-born male child of three years of age, was admitted to the hospital on April 6, 1930, after six hours of generalized convulsions. He was born by breech extraction, but his subsequent course had been uninterrupted, except for Rubeola at thirteen months.

On the day before admission a mild cough developed. No illness was apparent, although supper was refused that evening. At 7 o'clock the next morning he was found in convulsions, and was immediately taken to the hospital.

He was in the midst of a convulsion upon admission. The boy was well developed and nourished, there was moderate cyanosis, and his respirations were shallow and sterterous with irregular periods of apena. Auscultation elicited fine inspiratory râles throughout both lung fields. The deep tendon reflexes were hyperactive.

Oxygen therapy and sedatives were productive of some improvement, and the convulsions ceased temporarily. The blood sugar was found to be 37 mgm., so dextrose by phleboclysis was injected. Convulsions returned shortly, however, and exitus occurred about two hours after admission.

At necropsy there was a diffuse infiltration of the pharynx and trachea, with an early strepcoccal pneumonitis of the interstitial type. There was an associated edema of the brain with medullary pressure cone (?), acute splenitis, and cloudy swelling of the liver. The pancreas, grossly and microscopically, was normal.

Case 11.—H. B., an American boy of eight years, was seen by one of the authors on April 27, 1934, because of "acetone attacks" since infancy. His antecedents were good, and his birth and development had been normal.

The first attack was at the age of eighteen months, and began with hiccoughs and abdominal pain, followed by vomiting, generalized convulsions, and coma. Every few months the child had similar bouts for the next four years. They were invarlably accompanied by "acetone breath", occurred toward the latter part of the day or early evening and lasted about twenty-four hours. They seemed to be precipitated by over-exertion, anger, excessive fatigue, infection and excitement. His seizures were preceded by a voracious appetite, and in later years the mother learned that she could usually shorten them by the liberal administration of sweetened fluids. On one occasion, after an attack, the blood sugar was found to be "low", according to the mother. After an age of six years was attained, his attacks became less frequent. For the past fourteen months he has been symptom free.

Physical examination was of no particular moment, except for moderate undernutrition and lordosis of the fatigue type. His basal metabolic rate was 12.1 per cent plus. Dextrose tolerance showed: Fasting—95 mgm., 30 minutes—169, 60 minutes—113, 120 minutes—81, and 180 minutes—78 mgm.

SUMMARY

1. A brief summary of the literature on hypoglycemic convulsions in juveniles is presented, and eleven cases are herein reported.

2. A suggested classification of hypoglycemia is tendered. The etiology of this disorder is reviewed, and an attempt made to determine the mechanism of spontaneous hypoglycemia in infancy and childhood.

3. The incidence, characteristics, and general course of the condition in children are described, with a final consideration of its diagnosis, treatment, and prognosis.

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DIET IN THE TREATMENT OF ANOREXIA

By FREDERICK H. VON HOFE, M.D., East Orange, N. J.

Read before the Pediatric Section at the 170th Annual Meeting of The Medical Society of New Jersey at Atlantic City, N. J., June 4, 1936.

In treating the young child, a pediatrician is called upon to offer help in cases of anorexia possibly more often than for any other single complaint. The subject has indeed been discussed at length from many angles, and it may be fair to state that each physician seems to

have his own pet method in treating this commonplace complaint. With this in mind, one cannot approach the subject without some hesitancy. However, in all that has been written, the value of a special diet in treating these cases is not emphasized. Most writers discuss the value of proper management; and while this is important, yet it alone too often fails.

Over a period of time one is impressed by the similarity of diets that these little patients who suffer from poor appetites demand—both demand and receive. They regularly consume a high carbohydrate diet, and usually milk and carbohydrate represents their mainstay. With this in mind, and also with the knowledge that young children on the commonly prescribed diet for celiac disease usually have very keen appetites, it was considered logical to prescribe a diet low in carbohydrates, and also milk free. The response of appetite to this diet was striking; and now over a period of about ten years, it has been prescribed for a considerable number of patients with almost uniformly good result. In fact, if in a period of two weeks the result is not satisfactory, one becomes suspicious of some error in the routine about to be described.

These children receive a breakfast consisting of bacon, egg, a small slice of Swedish rye bread with butter, stewed fruit and a well-ripened banana. Orange juice or any other fruit juices may be included. A noon-day meal consists of broth or soup, but no creamed soups, meat, vegetables (but no potato), gelatin or stewed fruits, and again a well-ripened banana. At evening the little patient is given broth or soup again, vegetables warmed over from the noon-day meal, or a fruit or vegetable salad, cottage cheese, one small piece of Swedish rye bread with butter, gelatin or stewed fruit, and a well-ripened banana. Conversely these patients receive no milk, cereal, potato, puddings and bread-stuffs other than a small quantity of Swedish rye bread. The fruits are stewed with little or no sugar.

Proper management, of course, must be secured. If both grandmothers, spinster aunt, and mother all insist upon being present and entertaining the child during the meal, one is defeated in any attempt to correct the poor appetite. It is necessary that the mother and all others leave the child while he is having his meal, unless, of course, one is dealing with a child too young to feed himself. At the end of twenty minutes to a half hour the mother clears the table regardless of how little has been consumed, and indeed should surprise the child by her lack of interest. If the mother is too sympathetic and finds herself incapable of this routine, it becomes necessary to have a nurse or some intelligent relative carry out the plan.

It is essential that the little patients are not overtired. Often are they exhausted both physically and mentally. Their nervous systems are bombarded by too many routine stimulants, and not infrequently they have insufficient physical rest. Most animals will refuse to eat when tired, and it is unnecessary to state here that no method of treating anorexia can be successful if we are dealing with a nervously or physically tired child.

One difficulty not infrequently encountered in working out this regime is that the child may, unbeknown to all others, steal food. In a short period of time they may become so ravenously hungry that they find some way to secure more food—and always select carbohydrates. One child, although only five years of age, would awaken early in the morning and steal down into the kitchen and help herself. And this apparently continued for some time before the mother discovered it. Another little girl stole cookies from the kitchen cupboard and kept a supply under her bed. An older boy frequently helped himself to sugar after everyone had left the dining room. Cookies secured at neighbors' houses is a common source of disturbance.

Progress in the average case is evident in the course of a week. However, many children will receive the diet for two weeks before a striking change in appetite takes place; and occasionally, although rarely, almost three weeks pass before the appetite has improved sufficiently. Many of these children become hungry to the point that the parents are fearful that too much food is being consumed. It is fair to say that these patients become ravenously hungry. When this occurs, carbohydrates

are added in sparing amounts, and later small quantities of milk are introduced. A child is kept on a relatively low carbohydrate and low milk diet for any indefinite time. Later, if the appetite wanes again, the patient is immediately placed on the original diet, but for a short period of time only. Very often in five days the appetite has improved sufficiently to warrant the increase in carbohydrates and milk again.

Loss in weight, not infrequently as much as a pound, is not uncommon during the first week or two, but with the improvement in appetite this loss is soon made up. Usually some gain is made simultaneously with the ingestion of greater quantities of food.

A certain number of these children become very irritable, almost unmanageable after being on this diet for some time; and the administration of calcium will quite regularly correct this condition. In fact, more recently these children have been given calcium in view of the fact that they are on a relatively low calcium diet.

In an attempt to explain the enhanced appetite, a number of children were tested for blood sugar before and after the diet was introduced. It was thought that the low carbohydrate intake might promote a low blood sugar; and this, as in the case of administering insulin, might be accompanied by enhanced appetite. These findings were disappointing. In most cases the blood sugar remained unchanged. A few showed some decrease, and one showed an increase following the institution of the prescribed diet.

Many methods of improving a child's appetite have been recommended. Yeast and other vitamin B preparations, I believe, have little or no value in these cases. However, I expect a patient suffering from vitamin B deficiency may definitely show some improvement in appetite upon introduction of the deficient vitamin. Insulin is of value, but most often the results are only transitory. Usually following insulin treatment the appetite reverts to its former condition. However, an occasional child will continue to eat well even after treatment, and this, I believe, may be explained by a change in the individual's habits regarding the amount of food consumed.

It would be impossible to compile a list of the medications that have been suggested and used to promote appetite. Bitters and tonics may at times seem to be of value; but I think we must all admit that their value at best is uncertain, and indeed cannot be counted on for any length of time.

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THE EARLY DIAGNOSIS OF CANCER OF THE BREAST

By George Blackburne, M.D., Newark, N. J.

Presented at the Clinical Meeting of St. Michael's Hospital, Newark, N. J., May 14th, 1936.

My serious interest in cancer of the breast dates back about sixteen years. Previous to that time I had operated upon a few cases, and had assisted at many others. In 1920 Dr. Alex Carel had come out to address the surgical section of our Academy of Medicine, and while driving him to the meeting, he asked me about my experience with carcinoma of the breast, and what proportion of the cases I had operated upon did I consider cured. I told him at that time that I thought over 50 per cent were cured, and he smiled and made no further comment. It seemed almost as if my reply had acted as a boomerang, because scarcely any time elapsed before several of my supposedly cured cases either appeared with secondary metastasis or I received word of their condition from other sources. Only in the past few months I have been called to attend to two of my own cases, apparently well following radical operation ten and eleven years ago, respectively, both dying—one from extensive local recurrence, and the other from bone metastasis. It can be readily appreciated that

I am deeply interested in a subject in which I have received so many jolts.

As people are becoming more cancer-minded, through education sponsored by the profession, more and more women appear for early diagnosis of breast lesions. They used to wait until a tumor was quite large, and the pain was a predominating symptom before presenting themselves. In the following paragraphs I will try and outline the various methods in diagnosing which I have learned to use in the consideration of breast tumors, and which have been of service to me.

The age of the patient gives us a clue, as carcinoma is very rarely found in women under thirty. The Mayo Clinic reports that two-thirds of the cases have been in women between forty and sixty. Men account for only one per cent of the total cases. Some fixation of the skin is present in the majority of cases. Pain is not a prominent symptom. Retraction of the nipple is likely to occur in the centrally located lesions.

Discharge from the nipple, if of an apparently sanginous nature, should be examined microscopically; and if it is true bloody discharge, that is a significant point in favor of malignancy. If not blood, the case is more probably one of cyst-adenoma, in which case, excision of the affected duct or ducts will effect a cure.

The location of the tumor has some bearing upon the diagnosis, as cancer occurs most commonly in the upper lateral quadrants or beneath the nipple.

An x-ray of the chest, lumbar spine and pelvis may show evidences of early metastasis, which would of course clinch the diagnosis. Recently, stereoscopic x-ray pictures of the breasts have been advocated as a valuable aid in the diagnosis of the breast tumors. They are of particular assistance in cases of large, heavy breasts, and when made and interpreted by an expert, are very accurate and reliable in differentiating the various types of tumors.

Transillumination has proven of some value (holding a frosted bulb under the breast and looking from above downwards through the gland, shielding the bulb, and directing the light through the breast). It is particularly useful in diagnosing cysts containing clear fluid from solid tumors. Inflammatory processes show a more diffuse opacity than solid tumors, when viewed by this method.

Frozen sections, after an excision of an entire small tumor, or a piece of a larger one, should be made in the operating room in cases of doubt, being prepared to proceed immediately with a radical excision in case of positive findings. I use the electric surgical knife for these cases, and also for the complete operation when indicated.

Chronic cystic mastitis gives a bilateral shotty breast and may show some nipple retraction. These cases are often benefited by ovarian residue taken internally, and this therapeutic test may be used with advantages in selected cases.

In examining a case of breast tumor it is best to see the patient between menstrual periods, as there is then less congestion of the gland. Have the patient lie down on her back; and stand at the head of the table, palpitating both breasts from above with the palms of the hands. The age is considered, history of the tumor, fixation of the skin, retraction of the nipple, discharge from the nipple, swelling of the arm, and palpable nodes. Transillumination is then tried, and if the patient has a very heavy breast, x-ray is considered. In doubtful cases, biopsy, to be followed by immediate excision in cases of positive findings, is advised.

Recurrences are usually manifest inside of three years, either at the site of the original tumor, in the mediastinum, abdomen, long bones, or spine. The present mortality, over a period of ten years, is given by reliable sources as about 90 per cent, regardless of the treatment followed. I have upon several occasions had the opportunity of seeing an entirely untreated case in a woman who resisted all suggestions for operation, radium, or x-ray treatment. She lived with her cancer for over twelve years before she succumbed to sloughing, secondary infection, and metastasis. In view of our statistics, it would seem that this entirely untreated case outlived 90 per cent of the treated cases. However, it is not an argument against early diagnosis and radical excision.

CHRONIC APPENDICITIS
ITS ROENTGEN DIAGNOSIS

By Ernst A. May, M.D., F.A.C.R., East Orange, N. J.

Read before the Radiological Section of The Medical Society of New Jersey at its Annual Meeting in Atlantic City, June 4, 1936.

The appendix filled with radio-opaque material was first visualized on the roentgen screen by Béclère in 1906. There are also other early reports by Bennett, Holzknecht, Case and Grigorieff. Since then a great number of articles have been written on ronentgen diagnosis of chronic appendicitis, each author evaluating the importance of the different roentgen signs according to his own experience. Today, we are aided by the improvements of the modern x-ray equipment, especially by the *serial exposure* device, which permits us, while fluoroscoping, to record on the film any detailed image of interest or importance.

While in acute and subacute appendicitis the clinical manifestations are sufficient to reach a proper diagnosis, the symptoms in the chronic form of this disease are very frequently so vague that they may point to gall-bladder, stomach, intestines, or kidneys, and may not point to the appendix at all. On the other hand, some authors say that one out of three cases is operated for chronic appendicitis; and that after the operation the patient continues to complain of the same symptoms as previously suffered. From the standpoint of the laboratory findings, which in almost every adult will confirm the diagnosis that the appendix was at one time inflamed, the operation may have been justified. An appendix which has undergone inflammatory changes at some time during the life of the patient, may, however, not cause any further disturbance. Only when it actually forms the underlying cause of the various symptoms, of which the patient complains, should it be considered as chronically inflamed; and only in this instance will the removal bring about a complete recovery.

Connell summarizes the situation as follows:

"Inasmuch as it is difficult to gauge the extent of the pathology in chronic appendicitis from the symptoms, before the abdomen is open, as it is still difficult from the gross pathology after the abdomen is opened and the organ is palpated and inspected; and as it is still difficult from the histopathology after the appendix has been removed and subjected to microscopic study, one may anticipate a certain degree of complexity and difficulty in a study of the subject of chronic appendicitis. * * * One might say of this condition that it is the most treated and the least diagnosed surgical disease."

THE BARIUM ENEMA AND THE APPENDIX

It is not surprising that under these circumstances one turned to roentgenology as the most reliable method of study. The roentgen examination can determine better than any other to what extent a pathological appendix enters into the clinical picture of the case. Not only can one expect from an exhaustive examination to find the anatomical changes, but one can also investigate the disturbed function of the appendix itself and of the other organs. For this reason the examination should be considered incomplete without a gastro-intestinal series including the gall-bladder, in addition to a thorough clinical examination. The barium enema alone sometimes gives sufficient information as to the pathology of the appendix; but if it leaves the slightest doubt and if the data obtained thereby are not conclusive enough, the examination should be extended over the entire gastro-intestinal tract.

Normally, the appendix fills readily with barium within six to twenty-four hours after oral administration. In some cases in which the appendix is filled with fecal material it will expel its contents only under the influence of a cathartic, and afterwards fill with barium.

Czepa gives two teaspoonsful of epsom salt in the barium meal directly, while other authors give a cathartic only in cases where the appendix does not fill. Only after two or three attempts to fill the appendix have been futile should one be permitted to draw the conclusion that the lumen of the appendix is obliterated.

FLUORCSCOPIC PICTURE

The fluoroscope offers the most important information during the examination. The patient is placed best in a recumbent position, but the upright position will also give valuable information as to the fixation of the appendix by adhesions. The palpating hand will isolate the appendix from the cecum and thus bring it into vision should it not extend downward. Its exact position will be determined and marked on the abdominal wall. This aids the surgeon materially in making the incision and finding the appendix. Should palpation not produce the appendix, turning the patient in an oblique or lateral position will help to discover its retrocecal location.

The normal appendix varies somewhat in thickness and length. The average thickness is one-half centimeter, and the length from eight to nine centimeters. There are three forms:

a. The fetal form, in which the appendix begins in the shape of a funnel at the lowest pole of the cecum with no sharp definition (25 per cent of the cases). (Fig. 1.)

b. A rare variation of the fetal form where there is a marked definition between the cecum and the appendix, the appendix having an even thickness throughout. (Fig. 2.)

c. The most common shape in adults is where the appendix originates somewhat medially and posteriorly to the cecum. (Fig. 3.) This is produced by the more rapid growing of the lateral and anterior wall of the cecum during infancy.

The filling of the appendix is essentially produced by the activity of the cecum. The emptying, however, occurs by the function of its own circular and longitudinal muscularis. The time of emptying varies from a few hours to a number of days.

As late as 1926 some authors considered every appendix which they could see on the x-ray film as pathological. This viewpoint has been abandoned. Today we endeavor to interpret roentgenologically the anatomical and functional condition of the appendix. For this reason we place more importance on the direct signs which the pathological appendix offers, than on the indirect signs coming from the organs nearby. The inflammatory process which the appendix has undergone has produced certain changes in the wall, such as scars, and total or partial stenosis. An abscess may have remained which has not been totally absorbed. Adhesions may be present, which keep the appendix in a certain position, or may attach it to other organs and interfere with its mobility. It must be borne in mind, however, that an appendix fixed tightly on a loop of the ileum may not show any symptoms of adherence at all. (Fig. 7.) If it reaches far over to the left side, the patient will complain of pain in the left lower quadrant. (Fig. 5.)

All these conditions are expressed in certain phenomena, which must be interpreted correctly by the roentgenologist. The diagnosis should never be based on one symptom alone, however conclusive it might be. The greater the number of signs which are found of a disturbed anatomical and functional condition of the appendix, which can be correlated with the clinical history of the case, the more exact and convincing will be the diagnosis. Only thus can we escape the pitfalls of wrongly interpreting a completely arrested pathological appendix which does not cause any disturbance at all, and avoid an operation which is unnecessary and will not rid the patient of his ailment. For this reason, the clinical result, not the pathological report, can be the only criterion as to the correctness of our diagnosis.

A fixed or kinked or obliterated appendix may prove that at some time it has undergone inflammatory changes. The adhesions which have formed may not interfere with the function of any organ. As soon, however, as the appendix is found to be tender upon pressure, these findings gain in importance, especially if the tenderness is found over the actually visualized appendix. (Figs. 6, 8, 10, 11.) All authors agree on the importance of this sign of local tenderness. Scholtz accepts it as the only true sign which permits the diagnosis of chronic appendicitis. To me it is the most valuable, but not the only symptom.



DIAGRAMS OF APPENDICES

1, 2, 3.—Normal appendices.
4, 32, 33.—Fecoliths in appendix tip.
5, 22, 23.—Extremely long appendix with tip fixed in one side of the abdomen.
6 to 10.—Appendix fixed and kinked, and tender upon pressure.
11, 31, 32, 33.—Appendix fixed to lateral abdominal wall; 12, 29, 30, on colon ascendens; 14, 18, on ileocecal valve; 13, in liver region with cecum curled upward.
19.—A long string of adhesions reaching from the appendix region to spastic area on colon ascendens.
16, 17, 33.—72 hrs. barium rest in cecum, appendix remaining filled for much longer time.
20, 21 25, 26, 27, 28.—Loss of peristalsis, tender on pressure.
31.—Gas in appendix.
15, 34.—Non-filling, appendix obliterated.
35, 36.—Partly filled appendix with one-way stenosis.
22 23.—Partial stenosis.

FILLING DEFECTS

Next to it I consider in importance the failure of the appendix to fill totally or partly, but only after two or three exhaustive attempts with a barium and epsom salt mixture have failed to fill its lumen completely. (Fig. 34.) A retrocecally adherent appendix, though filled, sometimes escapes the eye of the examiner, no matter how much he tries to bring it into vision, but it may appear later after the cecum has emptied its contents of barium. (Fig. 18.) Frequently even a mild inflammatory process will cause a complete obstruction of the appendix lumen at any area between the base and the tip and will permit the barium only to penetrate as far as the stricture. The appendix shadow then will appear to be short or not appear at all. (Fig. 35.) The stricture may only be partial and permit the barium to penetrate beyond and appear as a filling defect. (Fig. 22.) It may act even as a one-way valve and retain the barium for a long time.

Filling defects, on the other hand, may be produced by fecoliths or ordinary fecal matter free from barium or by mucous plugs in an otherwise normal appendix. (Figs. 4, 32.) In these cases the diagnosis will be aided by the degree of tenderness, and by the finding of other signs.

Segmentation or rosary form of the appendix shadow is not indicative of pathology. (Figs. 20, 23, 26, 28.) The different segments are produced by contractions of the appendix wall. Caution must be used in cases of total absence of the appendix shadow not to lay too much importance on the finding of a tender area in the lower right quadrant, as this tenderness may not be from the appendix at all, but may come from the adnexa or a stone in the ureter.

FIXITY OF APPENDIX

Third in importance of the direct signs is the finding of the appendix fixed in one position throughout the entire examination. This leads to the conclusion that it is caused by adhesions to retain a certain unnatural position, frequently with kinks, or with firm attachments to the cecum (Figs. 18, 19, 24), the ileum (Fig. 27), the abdominal wall (Figs. 11, 31, 32), or even to the liver region (Fig. 13). Retention of barium and other matter, as stated before, may be due to stenosis of the appendix lumen. It may lead to constant irritation of the part beyond the stricture (Fig. 23). An appendix fixed at its tip may also lose the power of contraction and retain the barium for a long time (Figs. 9, 25, 26). It is reasonable to assume that, if other signs of pathology have been found, to corroborate the diagnosis, an appendix which is filled for longer than three to five days, has lost by previous inflammation its power of peristalsis (Figs. 6, 13, 18, 22, 24, 28).

DISTAL SYMPTOMS

All these local symptoms are usually accompanied by distal symptoms, which in turn are produced by anatomical changes, directly or by reflex action. The anatomical changes are most commonly caused by adhesions to the cecum, the ileo-cecal valve, or the terminal ileum. They interfere with the function of these organs and disturb the mechanism of the ileo-cecal valve, or produce a stricture of the last part of the ileum. (Fig. 18.) They may also result in cecal or ileal stasis. If this stasis is demonstrated by a ten-hour residue in the terminal ileum, in conjunction with an excessive accumulation of gas and abnormal motility of the distal loops of the ileum, frequently one finds the appendix partly or totally adherent to the cecum. (Figs. 11, 15, 16.) The appendix then lies posteriorly or medially, and may not give rise to any disturbance unless the terminal ileum is also adherent, or unless the adhesions have produced a twisting of the cecum. The cecum then may be looped laterally or posteriorly and show the symptoms of cecal stasis with pain beginning about twenty to twenty-four hours after the barium meal was taken. (Fig. 12.) Through traction, a lack of proper function of the ileo-cecal valve is most common. It permits in these cases a retrograde filling of the terminal loops of the ileum. Conditions similar to those described before are often found in postoperative cases.

REFLEX SPASMS

The symptoms produced by reflex action may appear as spasms on any part of the gastro-intestinal tract or the gall-bladder. (Fig. 10.) They may be expressed as pylorospasm, a spastic colon, or a poorly functioning gall-bladder; and may produce anorexia, obstipation, general tiredness, or all kinds of symptoms seen in a generally disturbed gastro-intestinal tract.

CONCLUSION

The roentgen examination is in combination with the clinical findings a valuable means for the diagnosis of chronic appendicitis. The symptoms expressed by the shape and function of the different parts of the gastro-intestinal tract are manifold and must be interpreted according to their actual relation to the appendix, or to other organs. None of the symptoms is pathognomonic for a diseased appendix if found alone, but it gains in value if other local or distal symptoms are also found. In the order of their importance, they are as follows:

1. Tenderness over the appendix region, especially if the appendix is visualized.
2. Non-visualization of the appendix in toto or in part after exhaustive attempts to fill it have failed.
3. A fixed or kinked appendix.
4. Delay in emptying. (More than 3-5 days.)
5. Distortion of the cecum.
6. Cecal or ileal stasis.
7. Pyloric, cecal or colonic spasm.

Last but not least, a roentgen examination which discloses the fact that the appendix is not the cause of the patient's symptoms will contribute materially in clarifying the case and prevent the patient from undergoing an unnecessary operation.

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THE GALL-BLADDER AND THE GENERAL PRACTITIONER

By MARTIN E. REHFUSS, M.D., Philadelphia, Pa.

Read before the Section on Gastro-Enterology at the 170th Annual Meeting of The Medical Society of New Jersey in Atlantic City, June 4, 1936.

The study of gall-bladder disease has increased within the last few years owing to two great factors:

1. The unfailing contributions of the surgeon.
2. The persistent routine application of modern methods of diagnosis.

FREQUENCY OF GALL-BLADDER INVOLVEMENT

There is no question in the minds of those who are accustomed to studying abdominal disease that gall-bladder conditions are the most frequently encountered in the upper abdomen. Graham, Cole, Copher, and Moore made the statement that they believe from the work of others that 24 per cent of the adult population have gallstones, and that an equal number have cholecystitis without stone. This would indicate that perhaps 40-50 per cent of the adult population have disorders of the biliary tract which may give rise to active symptoms. If to this we add the autopsy statistics of Mentzer at the Mayo Clinic, and of Crump, it is probable that some form of biliary tract condition is found in one out of every two adults who die.

In our office in ten years, there were 908 cases diagnosed biliary tract disease which we

treated medically. I have no record of those who were recommended to surgery or referred elsewhere. In the same length of time, we had 281 cases of peptic ulcer. In about twenty years, we have seen over 2000 cases of biliary tract disease. In the same length of time we saw more than 500 cases of peptic ulcer; incidence of duodenal to gastric being more than ten to one. Other organic lesions of the upper abdomen were proportionately much less, so that there is no question but that biliary tract disease is the commonest disease in the upper abdomen. Not only do we have the evidence offered by autopsy statistics such as those of Mentzer and Crump, but we have the evidence which modern diagnostic methods have afforded.

There is every reason to believe that there is present in no small proportion of the population, physiological changes in the sequence of bilary tract function such as stasis, and likewise low-grade infections, which fail to produce symptoms such as would demand surgery. A careful appraisal both with the modern x-ray studies and the duodenal tube would demonstrate that there are many disturbances in function without direct evidence of organic change, —some of them transient, some of them permanent, most of them recognized by these methods. We can, therefore, assume that gall-bladder disease is an exceedingly common condition varying all the way from changes in function to marked organic disturbances.

RECOGNITION

The general physician today should realize the importance of this problem because I believe that it is possible to recognize early changes and to institute remedial measures. The diagnosis of gall-bladder disease today is based on four cardinal methods of approach:

1. The history.
2. The physical examination.
3. Duodenal intubation.
4. X-ray examination.

HISTORY

The history of the gall-bladder case is more or less characteristic. It is first of all an upper abdominal history. It is almost always punctuated either by characteristic attacks of known radiation, or by a form of indigestion which for the want of a better name might be called flatulent. The history of the ulcer case is very different from that of the ordinary gall-bladder problem, although the two may be associated. The same is true regarding the other primary conditions of the stomach, such as inflammations and new growths. While they may superficially resemble each other and at times be indistinguishable, the gastric symptoms due to a lesion of the stomach show a far greater association with food and a far more rhythmic effect. The reflex gastric disturbances associated with gall-bladder disease rarely show the same regularity or rhythm.

In our experience, nine out of ten gall-bladder individuals present *upper abdominal flatulence,* and in severe cases this may follow the ingestion of water as well as any food even though the average gall-bladder case is more sensitive to fats than any other variety of food. The typical case with biliary colic is not difficult to recognize, nor is the individual who has had sharp upper abdominal pain followed by jaundice. Much more difficult, however, are those individuals whose symptoms overlap and suggest gastric and duodenal disturbances as well as the possibility of biliary tract disease. In this group of cases, only careful study will differentiate the individuals and enable us to begin with the correct diagnosis.

PHYSICAL EXAMINATION

If there is one thing in the physical examination, it is residual tenderness over the gall-bladder. While it is possible at times to palpate the organ, while it is realized that the position of the organ is dependent upon the position of the lower border of the liver, we now know that it may vary markedly. Only today we saw a case where the gall-bladder was almost in the midaxillary line, and the tenderness corresponded precisely with the position of the organ at that point. It may be found in the lower right quadrant.

The most valuable point in physical function is unilateral localized tenderness. To this may be associated muscular rigidity over the upper right rectus; but a tender gall-bladder

is always a suspicious organ; and if you will make it a rule to compare the position of the gall-bladder on the x-ray with your physical examination, you will occasionally be surprised to find that the organ is not in the usual position and that the tenderness corresponds precisely with the position of the organ.

DUODENAL INTUBATION

Duodenal intubation is now a standard procedure. In this way, we can follow the sequence of events in the duodenum. There is certainly no occasion today to question the significance of dark bile or the importance of the color sequence found on duodenal intubation. Every physician should know how to use the duodenal tube, because he can obtain information by this means which is not obtained by any other method at his disposal. There is occasionally an individual who cannot be properly intubated. But in the great majority of individuals, this procedure is an easy one and the method employed is a standard one.

Every young physician who graduates today must know the technic of duodenal intubation. I have insisted upon three or four points which seem to me of paramount importance. The first is to follow closely the color sequence which involves the introduction of a stimulant in the duodenum. We are all familiar with the normal color sequence; and we also realize that the failure to obtain this sequence indicates that something is wrong. It is my belief that the failure in the normal color sequence is just as significant, and is usually due to the same factors which produce an abnormal cholecystogram. You can stimulate with peptone solution, dilute hydrochloric acid, 33 or 50 per cent Epsom salts solution or plain olive oil. I always insist upon the latter because I believe it is most convenient and powerful stimulus that we can use. If the tube is clearly in the duodenum, and this can be determined not only by the character of the material obtained, but also by fluoroscopy, if necessary, then the introduction of these substances should be followed by the characteristic appearance of a more concentrated gall-bladder bile. A failure to obtain this sequence may mean a block of the cystic duct, a gall-bladder filled with exudate, or even stone, or a gall-bladder mucosa so hopelessly infected as to completely fail in its function of concentrating bile. In any event this failure in color sequence may be simply transitory as in some physical disturbance or permanent as in many organic conditions.

It is most important that the observer regard the color changes at the bedside of the patient. The color of bile changes rapidly, and I sometimes feel that I would rather have a graphic first-hand report than a second-hand report issued from the laboratory. Only those of us who have done this thing many times at the bedside of the patient realize how important is this phase of the interpretation, and if there is one thing that I would impress on the minds of beginners in this work, it is the necessity for personally supervising this part of the procedure. I have had physicians and associates question the necessity for such close supervision. Only recently one of these individuals came to me and thanked me for insisting upon his following at first-hand this part of the procedure as he made a diagnosis which otherwise would have been impossible. All of this can be done by the general practitioner, and if he realizes what he is driving at, it will not be long before his interest is aroused and before he realizes how easy it is to obtain this information.

The second point is likewise one which every physician himself can perform, namely an ordinary *microscopic examination.* Cholesteral crystals and calcium bilirubin crystals are even more significant in the examination of the bile than crystal findings in the ordinary urinalysis. Here again an important examination of the aspirated and segregated specimens is far more important than a report on material which has been preserved in an ice-box or allowed to stand around in the laboratory; but microscopy does not stop at the demonstration of crystals. The student who can use a microscope will recognize many interesting points in the study of abnormal bile, such as cell exfoliation, leukocytes and even bacteria and pus, and parasites like the giardia.

After the student has performed this procedure a few times he becomes familiar with abnormal findings. Duodenal intubation and

drainage is not merely a diagnostic procedure, but it enables us to clear out and drain the biliary tract under controlled conditions. Time and again it is impossible to obtain a color sequence after one or two stimulants, and patience is rewarded by continued effort. Furthermore, one of the most satisfactory things about duodenal intubation is the improvement in sequence which frequently follows treatment. Unfortunately there is no other way to demonstrate the sequence of events in abnormal bile than by this procedure. All the trouble and time that it takes is frequently repaid by the findings and the subjective improvement of the patient. I have carried on this procedure since 1913; and in twenty-three years we have done it many thousands of times. I realize fully that surely a procedure can be exploited, and that occasionally the effects may be purely psychological; but no honest attempt in this direction can occur without the conviction that it is possible by duodenal drainage to markedly improve many functional conditions and many low-grade infections.

It would not be wise at this point to leave unsaid the fact that there are some contraindications. In our own work, we always do the x-ray study first; and if there is an inflamed or tender gall-bladder with stone, we proceed very cautiously or not at all. I have had three instances in all the thousands of examinations in which an acute crisis was precipitated, and demanded an immediate operation following this method. In each instance there was a smoldering calculous cholecystitis. We have had many instances where a mild flare-up occurred, but with no disastrous results. Coronary occlusion, advanced heart disease, an active calculous cholecystitis, and an active throat infection are to my mind contraindications.

X-RAY EXAMINATION

X-ray examination of the gall-bladder is now more or less standardized throughout the world. By means of cholecystography we can usually visualize the organ, see its form, ability to concentrate, contractability, demonstrate many abnormalities in form and position due to pericholecystitis and finally show stones which otherwise would pass unrecognized. I have spent some years, and even changed instruments, in order to improve our technic. Even though the technic today is standardized, the diagnosis depends upon factors which must be exactly controlled. A single button on the rheostat can cause a gallstone to disappear; and I have seen so many bad films in my experience that I have no hesitancy in saying that this procedure demands special knowledge and special equipment. If you have films of fine technical quality, then the diagnosis is usually apparent. There is no question whatever that x-ray diagnosis is directly proportionate to the technical excellence of the films, and the accuracy with which the method has been followed. When these demands are satisfactorily performed, diagnostic accuracy is very high. For that reason I do not believe that the general physician, or even the individual of little training, should carry out the procedure. On the other hand, for those who are trained in this work, x-ray studies not merely give us the key to correct diagnosis, but it is the most valuable method at our disposal to measure the progress of therapy. The general physician, therefore, can take a careful history, make a complete physical examination, carry on duodenal intubation; but as a rule, he should have this work performed by an expert observer. He is then ready to make a diagnosis; and as a rule the diagnosis will be entirely negative or it will point to a lesion of the biliary tract. For practical purposes, this lesion will either be a diagnosis of cholecystitis, or cholelithiasis, or both.

THE QUESTION OF OPERATION

It has generally been conceded that surgery is most successful when stone is present, and that all stone cases are potentially, if not actually, surgical. There is no question regarding the success of surgery in this type of case, but I for one have not followed this teaching. I have felt that there are many instances where stones were latent, and where the risk of surgery from other considerations was perhaps greater than the risk of stone. This is, of course, an individual matter. I have always explained to the patient that there is no cure

for stone except surgery; but I confess that at times I have not stressed surgery when there is present poor liver function, cardiac difficulties, renal disturbances, low blood pressure or conditions which generally place the patient in the category of poor risks. I have today many individuals with gallstones who know their problem but refuse operation; and I confess I have not felt it my business to insist upon it. It has been my experience that when individuals with stone fail to react to medical treatment, that they usually come to surgery of their own volition. There is no reasonable doubt that, when surgery can be safely performed, it is obviously the most satisfactory solution.

The noncalculous gall-bladder is a different story. Surgery has been by no means as successful, nor does it offer as satisfactory a solution, although the risk is just as great. I am of the opinion that every case of noncalculous cholecystitis should be offered the advantages of medical treatment precisely like the treatment offered to the peptic ulcer cases. Gall-bladder disease is an end result; and while the surgeon remedies the end result, he does not necessarily remove the antecedent factors that result in the condition.

MEDICAL TREATMENT

You may ask the question as to what can be done medically for these cases. I feel the evidence today warrants the statement that we can do many things. Times does not permit me to go into the question of mechanism of gall-bladder disease, but we can both directly and indirectly influence this organ.

Diet.—We now have a fairly accurate idea of the influence of the diet on gall-bladder disease. We know those foods which demand both increase and decrease in activity on the organ. We know that foods prepared a certain way may exert a marked stimulating effect; and prepared another way they may show no effect. We believe that the cholesterol metabolism is influenced by the dietary and we know that low-grade hepatitis, so frequently associated with gall-bladder disease, can be influenced one way or another by the selection of the diet. We know that in a fairly large number of cases the gall-bladder is infected.

We know the nature of the bacteria which infect the gall-bladder and we also know where these bacteria are likely to have occurred, before they induced gall-bladder disease. We have today considerable experimental evidence to show that many of the bacterial infections of the gall-bladder subside and may even disappear under favorable conditions. Only in this way can we explain a gall-bladder which was actively infected or inflamed and which was subsequently shown to be sterile on operative removal. We also know that many gall-bladders are removed which have been perfectly harmless. But as yet we know no method of gall-bladder removal which is safe from risk or could be considered as harmless.

We also know that many of the reflex phenomena like flatulent indigestion, spastic constipation, nervous and toxic disturbances can be controlled by satisfactory therapy. We know that the gall-bladder individual has a certain type of personality that he should live in a certain way, follow a certain diet, and get rid of focal infection; and when he does this in many instances, the picture changes. The patient improves and there may be objective as well as subjective evidence of improvement.

Our only medical criteria are those which are based upon the four methods of study; namely, a disappearance of all symptoms, a disappearance of physical signs, a resumption of the normal sequence and findings in duodenal intubation, and an improvement or restoration to normality on x-ray study.

There is no reason why we should not use every means of therapy on the continent; elaborate Spa treatment, the use of all the different forms of physio-therapy, and careful outline of dietaries are insisted upon. If all the ordinary means of hygienic supervision and dietary control would break up the vicious cycle by a well-directed medical therapy, and if we control and remove foci of infection and, where we can get the evidence, use some of the forms of bacterial therapy, it is surprising to note how much improvement can be noted in many of these individuals. The handling of diabetes today is one of organization and

direct control. No specialist claims to cure diabetes only to control it. When we establish means of organization and control in this problem far more common than diabetes, and we use the methods at our disposal, I am convinced that we can do a great deal toward alleviating the discomfort of these individuals. If we fail, we can call upon modern surgery with its marked reduction in mortality and its greater efficiency to aid us in obtaining a result. For this reason, I feel that the problem is one which concerns the general practitioner.

DISCUSSION

Dr. Anthony Bassler, New York City: It is interesting that the three most outstanding men on gall-bladder conditions, Dr. Rehfuss, Dr. B. B. Vincent Lyon, and the late Dr. John B. Deaver should have been Philadelphians. To each of them medicine is appreciative. I like Dr. Rehfuss' paper because it indexes a master who is helping the practitioner, giving a hand to the first contact man in the vast majority of the cases. Quoting from a recent paper of mine published in the New York State Journal of Medicine, I stated: "Deducted from the study of any condition in medicine, the specialist should pass on that of the worthwhile in routine and with particular satisfaction to general practitioners of medicine. This is one of the responsibilities of specialists not observed to the extent that it should be." Dr. Rehfuss has fulfilled this in his recent book and again today. I congratulate him.

No organ in the human body lives to itself alone. Many individuals do not inherit, or do not acquire, immunities to bacteria; and many inherit a metabolism easily de-stabilized. In much of this we today can only see as through dark glasses, and the apparently simple is often complex and difficult. Much of medicine is still hypothetic; and it is difficult to go from a hypothesis of supposition to an accurate conclusion. We today are limited to clinical syndromes produced by disease in which the gall-bladder is definitely pathological and then going about them in more or less pointed ways. With the exception of carcinoma, gangrene, empyema and perforation of the gall-bladder, there is much I feel about our medical and surgical concept today that will be modified tomorrow.

Like the appendix, the gall-bladder is an organ that can be removed from the body with safety to continued life. For twenty-five years I have studied the records of surgical divisions of several large New York hospitals on cholecystectomies and found quite uniformly that 50 per cent of those without stones and 27 per cent of those with stones had not been improved. The pathologists' reports are satisfactory enough to warrant removal, but the clinical results too often are not satisfactory. Three weeks in bed, low diet, abstraction from domestic and business worries and work while in the hospital and convalescing for several weeks more, and the moral effect from an operation help the statistics of cure from operations far more than surgeons and medical men give them credit for.

What is wrong? Is it our limited knowledge of the subject and thus our failures are excusable? Is it poor diagnostic work which largely is inexcusable? Is it poor diagnostic acumen in differentiating the surgical from the medical case which often again is inexcusable? Is it that the surgeon sees and judges too much with a surgical mind and a medical man with a medical mind, a mistake of limited viewpoint too often made? Is it due to continuation of the old surgical slogan, "To open up and see and do definite things to organs that are not exactly normal" preached for years by a generation of surgeons, many of whom are still with us, and which often means poor diagnostic work? Or is it due to the much more that all of us have got to learn about a subject that is far more complex than we have believed and thus a great stimulus for future study?

I have been a student of abdominal affairs long enough to appreciate that more mistakes are made in accurately diagnosing and handling disease and conditions of soft organs than the firm or solid ones; and the more hollow and tubular they are, the greater the mistakes and the greater the justice of conservatism.

Another thing I have learned is that the acute abdominal condition that does not subside after eight or ten hours' time, especially when not explainable, is largely a surgical affair; while the one that runs a continued course with no constitutional or laboratory symptoms of alarm, is mostly a medical affair. In these there are exceptions, of course. I state it only as an average clinical rule.

Following these tenets, then, the gall-bladder case with biliary colic, jaundice, ill health, empyema, gangrene, and perforation speaks words of warning quickly; and all others call for a halt of caution and signalizes study, time, temporizing and usually medical handling. How, when, or in what way one handles these medical gall-bladder cases with whatever means you or I believe in, remember that in addition to the gall-bladder, there are ducts, liver, constitutional, metabolic, and intestinal sides to it also, because, by looking at these cases with two eyes instead of one, one gets a stereoscopic vision of them and then one can see into the depths of what often is quite a complex and not a simple problem. "Time is marching on" in hepato-biliary tract diseases even though it has taken us a good many years to realize that gall-bladder disease is merely a part of an extensive pathology involving also the ducts, the biliary radicals and the liver; and back of the liver, an array of systemic, metabolic, and intestinal conditions. Books are written on the digestive system and tract, and the respiratory system and tract. I predict that the biliary system or tract, or better, the hepato-biliary system, will be graced by books embracing the whole of this subject.

CARDIAC ARRHYTHMIAS FROM THE CLINICAL STANDPOINT

By Thomas K. Lewis, M.D., Camden, N. J.

Read before the meeting of the Salem County Medical Society on December 11, 1936.

Heart disease today ranks without dispute as Public Enemy Number One. Not only does heart disease lead all other conditions in cause of death; but further, that block of individuals complaining of heart symptoms constitutes one of the largest groups of patients who seek the services of the medical profession.

In presenting this paper on "Cardiac Irregularities" we do not presume to give you anything new, but shall proceed on the proposition that a review of the subject, particularly stressing those clinic features which make a diagnosis possible with a minimum of instrumental assistance, will be of mutual advantage. Correct differentiation of the various irregularities, and an accurate evaluation of their significance, are of great aid in obtaining a true understanding of the relative gravity of the underlying heart condition.

PHYSIOLOGY OF THE HEART-BEAT

In approaching the subject of cardiac irregularities, it might be well to review briefly the several steps in the physiology of the heart-beat.

1. The contraction has its origin in the sino-auricular node, often called the *pace maker.* (This node is located at the upper anterior end of the sulcus terminalis, which begins at the conjunction of the right auricular appendage and the superior vena cava, running down toward the interior vena cava. The tissue of this node consists of a network of small spindle-shaped muscle cells, richly supplied by branches of the heart nerve.) Contraction begins in this node and spreads (2) to the auricles, whence it continues along (3) the auriculo-ventricular bundle often called the bundle of His. (This bundle of conductive tissue arises in the right auricle near the coronary sinus, and runs forward and downward to the membraneous septum of the ventricle, where it divides into two main branches, one going to the right ventricle and the other to the left. The ends of these branch bundles connect with the ventricular muscle by way of the cells of Purkinje.) The contraction impulse then continues on (4) to the ventricular muscle.

The pace maker has a normal contraction rate of from 150 to 160 per minute. This rate, however, is controlled or depressed by the inhibitory action of the vagus nerve, so that the average normal rate is held down to the neighborhood of seventy-two times per minute. In some cases, excessive vagus activity may slow down this rate to as low as fifty or sixty contractions per minute.

I. SINUS IRREGULARITIES

Sinus irregularities are divided into two chief classes: (a) The respirator type, and (b) the type without respiratory association. This latter group may manifest itself either as a sudden slowing; or as a phasic variation in heart rate. Both types are due to variations in vagus tone.

Recognition of sinus arrhythmias can be determined in the vast majority of cases without the aid of instrumentation by one or more of the following tests:

1. Almost all of the arrhythmias encountered in the first decade of life are of sinus origin.

2. A definite relationship of any arrhythmia to the respiration is conclusive evidence of sinus origin. In those few cases where this relationship is not apparent, deep breathing will almost always develop a respiratory association.

3. The radial and apex beats correspond in time and in volume.

4. Sinus arrhythmias disappear following exercise, during fever, and following use of amylnitrite or atropin.

5. Pressure on the vagus nerve, or use of the oculo-cardiac reflex, will frequently cause a disappearance of this type of irregularity.

Prognosis is practically always favorable. In fact, it is usually a phenomena of health; and when it is the only sign of cardiac abnormality, it should in no way alter the individual's

method of living, or be considered an indication of heart disease.

II. HEART BLOCK

Heart block is a disturbance of the cardiac cycle wherein there is a delay in, or absence of, the conduction wave of the auricular impulses through the bundle of His to the ventricle. There are a number of grades of heart block.

1. Simple prolongation of the interval between the auricular and ventricular contractions. This condition is commonly overlooked, and, frankly, can only be recognized by the electrocardiograph.

2. A further prolongation in conduction time results in occasionally dropped beats at greater or smaller intervals. This condition must be differentiated from extra systolic irregularity, and the pulse reading alone should not be accepted as evidence. Listening at the apex is necessary, because when an extra systole appears immediately after the previous ventricular contraction, owing to the fact that the ventricular chamber has not had time to fill with blood, this impulse will be lost at the wrist.

3. A further rise in the grade of heart block produces phenomena known as 2:1, 3:1, or 4:1 heart block. That is to say, when only every second, third, or fourth auricular impulse is transmitted to the ventricle.

4. The highest grade of the condition is known as complete heart block. Here absolutely no impulses are transmitted through the bundle of His to the ventricle. The latter, then, takes on and builds up its own rhythm of contraction, the rate of which is in the neighborhood of thirty times per minute. In this condition the auricles and ventricles are contracting at completely dissociated or independent rates.

Heart block is found as a temporary condition during or following acute infectious fevers, and sometimes during the acute stage of rheumatic fever and chorea. It may also be a temporary condition as a result of overdosage with digitalis. The permanent condition is encountered in senile individuals with advanced arterio sclerosis, in conjunction with obscure degenerative conditions of the myocardium, and in syphilis. The actual pathologic lesion demonstrated is fibrosis, atrophy, calcification or gumma.

Diagnosis in the milder phases of heart block can only be determined through use of the electrocardiogram. The second degree case with dropped beats can often be determined or at least suspected by listening carefully over the apex for the exclusion of possible extra systoles. In the 2:1, 3:1, 4:1 types of heart block, extra systoles having been excluded, the rate alone, which varies from forty to fifty per minute, gives rise to suspicion.

a. Where a jugular vein contraction or contractions can be spotted between ventricular impulses, one may be reasonably certain that the condition is heart block.

b. Exercise in this type of case often causes an abrupt doubling of the existing rate with an equally abrupt return to the previous level the minute exercise ceases.

c. In complete heart block the rate of thirty-five or less is almost always pathognomonic of complete heart block. The so-called *Stokes Adams syndrome* is not necessary for the diagnosis of complete heart block, for in young individuals the condition has been known to exist without subjective symptoms.

III. PREMATURE CONTRACTIONS OR EXTRA SYSTOLES

In the extra systole form of irregularity there is a deviation from the normal rhythm due to a sudden contractile impulse originated in the auricle, a-v bundle, or the ventricle, independent of the pace maker. Usually following this premature contraction there is no response to the on-coming nodal impulse due to the fact that the ventricle is in the refractory or rest stage. There then follows a long rest phase, following which the original rhythm is resumed. Again let me call attention to the fact that when this extra systole succeeds immediately the previous ventricular contraction, there is apparently a lost beat of the radial pulse.

Recognition of extra systoles depends on four points:

1. Except for the extra beat, the basic rhythm is undisturbed.

2. This type of irregularity almost always disappears during exercise and in fevers.

3. Frequently these off-time beats assume a regular relationship, producing what has often been called bigeminal or trigeminal pulse.

4. When encountered in advanced myocardial degeneration, these extra systoles are so frequent as to preclude the possibility of detecting the basic rhythm, and consequently they simulate auricular fibulation. In such cases instrumentation may be necessary to establish diagnosis.

Etiology and *Prognosis.*—The condition is rarely encountered under the age of ten, and is commonest between the ages of fifty and seventy. The majority of people who reach middle life will demonstrate this symptom from time to time. It frequently is encountered in conjunction with valvular heart disease, and as a result of trauma; but by far the largest number of individuals presenting this symptom give no evidence of cardiac damage. In fact, in a relatively large group of cases the cause is extraneous to the heart. Tobacco, digitalis, fatigue, states of malnutrition, disturbances of the autonomic nervous system, etc., are common causes of the phenomenon. Ofttimes the cause is never determined. The condition may appear with no demonstrable cause, exist for years, and just as suddenly cease for no known reason.

Subjective symptoms frequently are extremely troublesome, and give rise to some of the most stubborn forms of heart consciousness. In other cases, the subject is entirely unaware of the existence of the phenomenon.

IV. PAROXYSMAL TACHYCARDIA

Paroxysmal tachycardia is a condition in which from time to time the normal heart rhythm is interrupted by a series of rapid and regular contractions, ranging from 100 to 220 per minute, the series starting and ending abruptly. This phenomenon consists essentially of a series of rapid and regular extra systoles. It is elaborated from a single focus which lies usually or always at a point removed from the pace maker. This focus is commonly located in the auricle, but occasionally it may be found in the ventricle.

The *etiology* of this condition is that of damaged or ill-nourished muscle, and it is rarely encountered in cases of known valvular disease. It is most frequently manifested following prolonged febrile states, such as typhoid fever, septicemia, etc. The actual attack may be precipitated by exertion, powerful emotions, gaseous dyspepsia.

Recognition:

a. When the patient shifts from the prone to the upright position, there is no change in the ventricular rate.

b. Perhaps the most characteristic point of differentiation is the absolute abruptness of onset and termination of attacks.

c. Following, or in the interim between the attacks, ordinarily, extra systoles are frequently noticed.

d. The paroxysms may last for a few seconds, several hours and rarely ten days to two weeks.

e. Following the termination of the longer attacks large quantities of limpid urine are passed.

Significance: This condition is rarely indicative of true heart disease, and is ominous only when an attack lasts more than two or three days.

V. AURICULAR FIBRILLATION

Auricular fibrillation is a condition in which the auricles fail to contract in mass; but display fibrulary twitching which results in a gross irregularity of the ventricular rate commonly referred to as *absolute arrhythmia.*

Etiology: This condition is always indicative of organic heart disease, except when it appears temporarily during the course of acute infections. It is rarely encountered before the age of seventeen; and its great cause is rheumatic heart disease, although it may appear in the later years of life as a manifestation of advanced myocardial degeneration, aneurism, and syphilitic aortitis. Rarely tuberculous pleurisy and pericardial lesions are the etiologic factors.

Recognition:

a. Absolute arrhythmias with a rate over 120.

b. Exercise increases the irregularity.

c. During fevers the irregularity persists or tends to increase.

d. There is no relationship to respiration.

e. Response to digitalis medication is spectacular (provided the heart muscle has sufficient potential strength to respond to the medication).

Prognosis: This condition is always indicative of serious heart disease. When response to digitalis is prompt and satisfactory, the expectancy of life may be from ten to fifteen years; whereas failure to obtain satisfactory results from adequate digitalis administration implies marked limitation in the expectancy of life. When the heart rate cannot be reduced below 140, the patient rarely survives more than a few weeks or months.

VI. AURICULAR FLUTTER

Auricular flutter is a condition in which the contraction of the auricle follows a circular nerve-ending path entirely out of control of the pace maker. In this condition, the auricle as a whole never enjoys rest, and impulses pass through the a-v bundle at the rate of 240-350 per minute. It is beyond the capability of the ventricles to respond to this number of stimuli. Therefore, there develops a physiological, or compensatory heart block with a ventricular rate of from one-half to one-third of the auricular rate.

Attacks of auricular flutter may be transient or may last for many years. The theory has been propounded that this condition precedes in many cases the development of fibrillation, but this supposition has never been positively proven.

The *etiology* has not been definitely established. The condition is most frequently encountered in advanced years. Its relationship to infection has never been established. It is found to exist in conjunction with arteriosclerosis and degeneration of the myocardium. There is no known morbid anatomy.

Recognition: In many cases this condition can only be ascertained by instrumental methods. However, the condition may be suspected when a patient complains of palpitation, with a heart rate of 160 or more; and states that the condition has been in existence for a month or more. Occasionally during emotional stress, for a short time, the ventricular rate may arise to that of the auricles.

VII. ALTERNATION

Alternation is a condition where the heart beats alternate in strength,—that is, the left ventricle expels larger and smaller volumes of blood at alternate contractions. Occasionally this phenomena may be encountered during attacks of tachycardia; and in such cases it is of little importance, provided it disappears with the cessation of rapid heart rate. It is a more important and a graver manifestation when encountered in conjunction with a relatively normal heart rate, in which case it usually indicates advanced myocardial degeneration.

Recognition:

a. Is easily made by instrumentation.

b. Rarely, in the presence of high tension pulse, it may be detected by palpation of the radial pulse and in such cases presents the true phenomena known as pulsus alternans.

c. In most cases, it may be detected if looked for when taking the blood pressure by stabilizing the air pressure in the sphygmomanometer just below the first reading of systolic pressure. For five, ten, or fifteen points below that level, every other impulse will be shut off, the lost impulses appearing as air is released from the instrument.

Prognosis: Except when a transient condition complicating acute infections, it is a definite indication of grave heart disease. It has been stated that when this phenomena makes its appearance expectancy of life can not be beyond two years.

VIII. HEART CONSCIOUSNESS

Heart consciousness, while in itself not an irregularity; yet because of its frequent association with tachycardia and the arrhythmias, and because of the great need for ascertaining its true significance, it is included in this group. There is probably no commoner subjective cardiac symptom, nor any symptom more demoralizing to the mental stability of the subject, than heart consciousness. It is a curious and comforting fact that the most troublesome types of heart consciousness are often not

associated with grave heart conditions, but rather in trivial, or non-existent cardiac conditions. Unless quickly recognized by the physician at its true worth, satisfactorily explained in a convincing manner to the patient, this symptom may give rise to *a cardiac psychosis,* than which there is no more stubborn form of psychoneurosis. Many an individual has been doomed to years of mental suffering and physical incompetency because the physician first consulted has failed to appreciate the significance of this symptom, and has not definitely and conclusively carried assurance to the patient that heart disease does not exist. It is important to impress these patients with the fact that heart symptoms may occur in a sound heart as a result of extraneous influences, just as readily as headache may result from constipation or some other condition far removed from the head.

PSYCHOLOGY OF TREATMENT

Let me conclude this rather superficial review of cardiac irregularities with a few words about the importance of *psychology* in the treatment of heart disease. Because of the fact that the arrhythmias usually are either noticeable to the patient, or have been commented upon at some time or other by an examining physician, it is of utmost importance to establish positively the significance of the irregularity. We must answer the question: "Is this organic heart disease or not? and if so, exactly to what extent is the heart damaged?" There should be no hedging and no uncertainty in the final decision that is rendered. The truth has never killed anybody. Who, other than the patient, should be more accurately informed as to the true state of affairs when the heart is involved by organic disease. On the other hand, firm and convincing assurance of the soundness of that organ when no disease exists will often prevent an unnecessary invalidism. Within the last month I have examined a young girl of seventeen who has been raised as a weakling, denied exercise in school and the ordinary activities of childhood because many years ago some physician had murmured the statement that there was something wrong with the heart. Since then no one seems to have had the fortitude to contradict that statement. Result—an anemic, under-developed child, with very much of an inferiority complex and an extremely unhappy outlook on life.

In the heart case more than anywhere else, we owe our patients, first, careful consideration and accurate diagnosis; second, evaluation of all cardiac signs and symptoms; and third, positive information, good or bad, to the subject.

47 South 27th Street

THE LOCAL MECHANISM OF PYLORIC CONTROL AND GASTRIC EMPTYING IN MAN

By HARRY SHAY, M.D.; J. GERSHON-COHEN, M.D., and SAMUEL S. FELS

From the Fels Fund. Read before the Section on Gastro-Enterology at the 170th Annual Meeting of The Medical Society of New Jersey in Atlantic City on June 4, 1936.

The motor function of the stomach and the mechanism controlling its emptying have attracted investigators since early antiquity. Even when philosophic speculation was the experimental method, gastric motor activity had been considered. Five centuries before the Pergalen laid the foundation stone of experimental physiology Aristotle had contemplated the slow gastric digestion of fat meat. In his "Problemata" he discusses not only the sinews of the stomach but also the somnolent effect of fat. "How", asks Aristotle, "does the stomach come to digest fat meat slowly?" "Because", he answers, "it swims in the stomach. The best digestion takes place at the bottom of the stomach, where the fat does not descend. Those who eat fat meat are sleepy, because their digestion is hindered." * Since then, innumerable investigators have studied the motor phenomena of the stomach, yet twenty-five

* (Quare stomachus carnes ulade pinques tarde digerit? Respondetur quia tales carnes natant in stomacho. Modo optima digestis fit in profundo stomachi, ubi carnes pinques non possunt venire. Itaq; tales sunt multum somnalenti, post esum pinquium carnium, quia in eis digestio retardatur.)

centuries have been inadequate fully to explain the problem.

The problem we are here discussing had its best impetus in 1895 from Roentgen's discovery; a discovery which was applied almost at once to the study of the motor function of the stomach.

We [1, 2, 3] have investigated the local mechanism of gastric motility in man in the intact gastro-intestinal tract and in the resected stomach with both liquid and solid meals. Elsewhere we [1] have reviewed previous studies by others.

EXPERIMENTAL METHOD

All studies were made on human subjects by means of roentgen examinations. The patients were completely studied in order to rule out as far as possible any organic gastro-intestinal disease. Cases were selected to represent the entire range of gastric acid secretory response, from achlorhydria to hyperchlorhydria. All patients were repeatedly subjected to duodenal intubation over a period of weeks so that psychic factors resulting from intubation were eliminated. Standard conditions for the complete study were insisted upon. No drugs were permitted; no studies were made if the patient had had any psychical disturbance during the preceding day. The evening being the best available time for the examinations, the following was the routine employed: The patient was permitted to eat his usual lunch at noon; and at 3:00 p. m., two slices of dry toast and a cup of tea without cream were ingested. Nothing was taken thereafter until 8:00 p. m., when the studies were begun.

The liquid test meal consisted of 250 c.c. of lukewarm tap water containing two ounces of barium sulphate. All test substances in this group of experiments were added to the water and barium meal, the total volume remaining constant. The gastric emptying time for each subject under the standard conditions was determined with the water and barium meal. This was checked by a second study, and rechecked at the completion of all the tests. Under the conditions outlined, we found very little variation in gastric emptying in the same individual with similar test meals. In most instances, the results were practically identical, and in the others the fluctuation did not exceed 10 per cent. Patients in whom a variation of greater degree were found were not retained for these studies, because we felt that extraneous factors were modifying the gastric motor response.

The emptying time for the water and barium meal established, new studies were made in which a variety of substances were used and their effects studied. These included hydrochloric acid in concentrations of the meal of 0.09 and 0.53 per cent, sodium bicarbonate (one and five per cent) solutions, normal saline and five per cent sodium chloride, five per cent solutions of glucose, as well as multiples of isotonic glucose up to 40 per cent solutions, milk, cream, lactose in the concentration present in milk and casec in similar concentration, olive oil, cottonseed oil, linseed oil, mineral oil, and glycerin. Food irritants, such as pepper and organic acid, in the form of oleic acid, were used.

The effects on gastric motor function and on the action of the pylorus were studied serially by fluoroscopic and roentgenographic examinations. Observations and records were made during the first five minutes after the ingestion of the meal, the patient having been urged to drink rapidly. Records were made at fifteen, thirty, sixty, ninety, and at 120 minutes after ingestion; or at such time when complete emptying had occurred or a constant residue with the water and barium meal had been obtained.

The effect of the various agents was then studied during their direct application to the duodenal mucosa. Standardization of individual gastric emptying was determined as above. In addition, gastric motility was determined after duodenal intubation, in order to note any mechanical effect of the tube. We found no change in gastric motility to result from the mere presence of the tip of the tube in the duodenum and of the tube through the pylorus. Serial roentgenographic data were recorded as before.

The duodenum was first intubated with a Rehfuss tube. The test agent was then slowly instilled into the duodenum while simultane-

ously the water and barium meal was taken. The duodenal instillation was regulated with a Murphy bulb, the rate of instillation ranging from twenty to 100 drops per minute.

Solid meal studies were done entirely with mouth meals. The basic meal consisted of 100 grams of baked potato, fifty grams of barium sulphate and 25 c.c. of water. The various test substances were then substituted for portions of this meal. If solid test substances were added, the weight added was substituted for an equivalent amount of potato; if liquid was added, it replaced an equivalent amount of the 25 c.c. of water.

The effect of acid and alkali has been previously reported.[1] From those studies we believe that with an intact gastro-intestinal tract the pylorus is the local mechanism which determines evacuation. We also were impressed by the fact that the local stimuli which activated the mechanism which produced pyloric closure arose from the intestinal mucosa, and that the gastric hydrochloric acid was the normal intrinsic agent, which, upon its arrival into the duodenum, acted as the mucosal stimulant. In that report we also stressed the action of other agents added by the food, which through chemical or physical action can activate this mechanism. Of these extrinsic factors fat [2] is probably the most potent, and our studies with milk and especially with cream show the effects of different concentrations of fat.

The decreased gastric motility incident to the presence of fat in the upper digestive tract was noted by Ewald and Boas [4] a half century ago. Their observations have been repeatedly corroborated, and have found a particularly confirming interpretation in the report of Lintvarev [5] in 1901. He concludes that fats introduced into the duodenum reflexly close the pylorus and do not permit any liquid to pass from the stomach for a considerable time. In our own studies with milk, cream, and fats in the human subject,[2] we have seen rapid pyloric closure, and even antral spasm, follow rapidly upon the entrance of fat into the duodenum. The effect of cream was much more intense than that of milk. Since the milk and cream we used did not differ essentially except in fat content, it is reasonable to attribute the quantitative difference in reaction to this factor.

When milk was substituted for the water in our test meal, we found that the gastric residue at the patient's normal emptying time ranged from 30 to 75 per cent. The gastric residues with the cream-barium meals were always greater than those with the milk meal. The duodenal instillation of milk as little as fifty drops per minute caused a marked delay in the gastric evacuation of the water barium mouth meal. The gastric delay was so much greater after the cream instillation that as little as six to nine drops of cream per minute in the duodenum resulted in a 90 per cent gastric retention of the water barium meal. In patients with quiescent duodenal ulcer, the results of these agents by mouth or intraduodenally were essentially like those obtained with normal individuals.

The results obtained with solid meals did not differ from those obtained with the liquid mouth meals. The response of the partially resected stomach to intestinal stimulation did not differ qualitatively from that of the intact stomach. It did differ quantitatively in that it required a stronger stimulus in the partially resected stomach to produce the same slowing of gastric emptying noted in the intact stomach. This led us to believe that the gastric musculature about the stoma acts as a substitution mechanism for the pylorus; but as would be expected, it does so less effectively.

In all of our studies of the local mechanism of gastric evacuation we have attempted to evaluate the three factors which are generally considered; namely, gastric peristalsis, gastric tonus, and the state of the pylorus.

It is readily understandable how a ring of contraction moving forward in the stomach should appeal as an explanation for the propulsion of food through the stomach. From our observations, we found that peristalsis generally appeared in the stomach immediately the head of the ingested column had entered the cardiac end of the stomach. Sometimes the waves were so shallow as to be observed with great difficulty; at other times they were deep, and appeared with a rapidity and intensity of action that was striking. Ordinarily evacuation took place while gastric peristalsis

was discernible, but adequate gastric evacuation occurred without any signs of peristalsis, especially in cases of anacidity. We also do not subscribe to the view that gastric contents enter the duodenum at the completion of each peristaltic wave.

In gastric tonus, we believe, lies the force that is primarily concerned with gastric emptying, but only when the pylorus is open. This factor is not so directly observable by x-ray as is peristalsis. The reason lies in the fact that differentiation cannot be made between a diminution in size of the gastric silhouette resulting from evacuation, and that produced by increased tonus. Inferentially, however, we may assume from our results in the emptying of isotonic meals by the achlorhydric stomach, that tonus, in the presence of an open pylorus, is an important factor in gastric evacuation. Here, these meals may pour steadily through the pylorus without a sign of gastric peristalsis. Knowing from experiments on the effect of gravity on gastric emptying that this was not an important factor, we felt justified in attributing the emptying to gastric tonus.

In our studies with milk the pylorus appeared to be closed and spastically contracted during the early stages of digestion. With the cream and fat meals this often was reflected backward into the antrum, and forward into the cap, thus confirming what we had observed in our acid and alkali studies: that the duodenal cap, pylorus, and antrum of the stomach behave, from the motor standpoint, as a physiological unit. We also saw with these agents what appeared to be a reciprocal relationship between pyloric closure and gastric peristalsis: that is a rapid cessation of gastric peristalsis when marked pyloric closure results from duodenal stimulation.

The rapidity with which pyloric closure, cessation of gastric evacuation, and diminution of peristalsis follow duodenal stimulation with many of the agents, leads one to believe in a probable nervous pathway for the stimulus. Nevertheless, the results of Quigley, Zettleman, and Ivy [6] make a humoral factor essential, at least as part of the mechanism. This has been demonstrated in the total gastric inhibition of their entire stomach pouch preparations in dogs, following the duodenal injection of fatty substances, and, more recently, in the autotransplanted denervated pouches with carbohydrates, by Quigley and Phelps.[7]

Our experimental data indicate that in the intact gastro-intestinal tract the pylorus determines gastric evacuation. The local mechanism of pyloric control is lodged in the duodenum. This is activated by intrinsic and extrinsic agents. The intrinsic agent is the gastric hydrochloric acid; extrinsic agents are contributed by the food in either chemical or physical form,—chemical probably when acid, physical when in hypo or hypertonic states. The most responsive part of the mechanism is apparently lodged in the proximal part of the duodenum. Although the pyloric mechanism can be activated from parts of the intestine distal to the duodenum, the response to the same stimulus diminishes as the distance from the pylorus is increased.

In the resected stomach the response is similar in kind, but quantitatively less marked for the same stimulus applied in the intact gastro-intestinal tract.

It has been shown also that gastric evacuation of a meal cannot be properly evaluated unless the gastric secretory response is duly considered.

Because the character of gastric emptying is directly dependent upon the gastric acidity and the physico-chemical make-up of the meal, no gastric operation basically alters gastric evacuation. It is further clear that roentgen reports of gastric evacuation must consider the type of opaque meal used. It is obvious that one cannot compare motor studies done with water-barium, milk-barium, chocolate sweetened barium meals, etc., because the fraction, other than barium, is such an important factor in determining gastric evacuation.

We did not find any essential difference in the behavior of the stomach to the various duodenal stimuli in the normal and in patients with duodenal ulcer.

SOME COMPLICATIONS DURING PREGNANCY

MATERNAL WELFARE—ARTICLE NUMBER THIRTEEN

By Charles Mazer, M.D., Philadelphia, Pa.

Abstract of an address given before the Middlesex County Medical Society, at its regular monthly meeting on November 18, 1936, in Metuchen.

ABORTION

Abortions are divided into:

a. Threatened.
b. Inevitable.
c. Complete.
d. Incomplete.
e. Habitual.

Abortions occur in women who have been sterile for many years about three times more frequently than in normal women.

THREATENED ABORTION

Threatened abortion in early pregnancy, without dilatation of the cervix, is treated with:

a. Rest in bed during entire bleeding period, plus three days more.

b. Thyroid extract, grs. one-quarter t. i. d.

c. Vitamin E. (The value of vitamin E is questionable.)

d. High calcium diet, including milk and cottage cheese.

e. Progestin, one rabbit unit every other day.

Administration of corpus luteum hormone, progestin, in doses of one rabbit unit every other day for three or four months, until the patient passes the aborting period, namely the fourth month of pregnancy.

Progestin inhibits uterine contractions; in fact, it has been shown experimentally that, if one rabbit unit of the hormone is given one hour before the administration of one c.c. pituitrin, it will counteract the pituitrin effect. Experimentally there has been observed a close relation between defective corpora and abortion.

INEVITABLE ABORTION

Inevitable abortion may be treated by one of two methods:

a. The uterus will empty itself entirely if the patient is kept in bed, and is given repeated doses of one c.c. pituitrin intramuscularly. Excessive bleeding requires vaginal packing.

b. If the patient is in a hospital under expert care and not infected, it is wiser to empty the uterus.

If infected, with spread to the parametrium, never empty the uterus, but use conservative treatment with diet, transfusion, etc.

HABITUAL ABORTION

The treatment of habitual abortion is:

a. Elimination of chronic foci of infection.

b. Treatment outlined for threatened abortion.

c. Thyroid for the first two weeks of each month, and sodium iodide in small doses the other two weeks, the dose being regulated by the pulse rate and basal metabolism readings.

FETAL DEATHS

Fetal deaths without uterine bleeding are seen occasionally. A sure diagnostic sign of fetal death in early pregnancy is the decrease of prolan B in the urine, with the oestrin remaining the same, or greater, in amount. The persistence of a pregnancy reaction in a case of suspected death of the fetus does not necessarily imply that the embryo is living. However, when the pregnancy reaction is repeatedly negative, death of the fetus may be presumed.

HYDATIDIFORM MOLE

The extraordinarily high concentration of the anterior hypophyseal-like hormone present in the urine and blood of patients with *hydatidiform mole* has been noted. A very minute quantity of urine will give a positive Aschheim-Zondek pregnancy test. The amount of anterior hypophyseal-like hormone excreted in cases of hydatidiform mole is from ten to five hundred times that excreted during normal pregnancy. The amount of prolan B normally excreted during pregnancy varies with the time of conception. At three months of pregnancy, as little as one minim of urine will give a positive rabbit test. In bleeding during the first three months of pregnancy associated with a dispro-

portionate enlargement of the uterus, the required amount of urine should be diluted ten to twelve times before being injected into the test rabbit; and if a positive reaction is obtained, diagnosis of a hydatidiform mole is certain.

CHORION-EPITHELIOMA

If a positive Aschheim-Zondek reaction persists later than eight weeks after the expulsion of an hydatidiform mole, or reappears after it was repeatedly negative, chorion-epithelioma should be suspected, even in the absence of abnormal uterine bleeding. Quantitative estimation of the hormone is then necessary. Chorion-epithelioma follows in about two per cent of hydatidiform moles. The Aschheim-Zondek test is both diagnostic and prognostic in this condition.

TOXEMIAS OF PREGNANCY

Pernicious vomiting is a manifestation of a toxic condition, and is best treated by glucose intravenously, a 20 per cent solution being given daily over a period of one-half to one hour. One unit of insulin to every two grams of glucose is given hypodermically. With an increase in the pulse rate and uric acid content of the blood, and with acidosis and jaundice present, the physician should interrupt the pregnancy.

Toxemia at the end of pregnancy, appearing out of a clear sky, shows itself by edema of the ankles and lower abdomen. Sometimes a typical gall-bladder attack is the first symptom. The blood pressure rises. The urine may or may not show albumin and casts.

Treatment consists of:

a. Rest in bed.

b. Low protein, high carbohydrate diet.

c. Glucose intravenously.

d. Hot packs.

e. Magnesium sulphate for the bowels.

f. Induction of labor if the condition progresses.

CONVULSIONS

When convulsions appear, give:

a. Morphine until the respirations are reduced to 12, and the pulse to 60.

b. Glucose intravenously after withdrawal of 12 ounces of blood.

c. Gastric lavage with three ounces of magnesium sulphate left in the stomach.

d. Sweating by means of hot water bottles.

e. Spinal puncture with the removal of 20 to 30 c.c. of fluid.

f. Delivery should be accomplished by other means than cesarean section after the symptoms are controlled.

MATERNAL WELFARE NOTES

CONSULTATION AND NURSING DELIVERY SERVICES

The consultation and nursing delivery service as arranged by the Committee on Maternal Welfare of the State Medical Society in conjunction with the Bureau of Maternal and Child Health of the State Board of Health has been used by a large number of the physicians of the State.

Any qualified physician may be called in consultation on a low-wage group case unless the patient is in a hospital with a regular obstetrical staff, in which case no fee is paid.

Any registered trained nurse may be called to assist at a delivery on a low-wage group case. The nurse should spend at least three hours with the patient, preparing her for delivery, holding the fundus at least one-half hour after the placenta is delivered, bathing the baby, and giving the patient ordinary nursing care.

In filling out the slips to be sent in, which are obtained from the field physician, the physician should take care to:

1. Write legibly.
2. Fill in date of birth or consultation.
3. Answer all the questions.
4. Give his address when signing the slip.

This will be of great assistance to the chairman.

SEASONABLE P

℞ AN EFFECTIVE ANALGESIC

Prescription No. 7 Compound Acetanilid Capsules N. J. F.

May be prescribed by title as follows:

Capsularum Acetanilidi Co., N. J. F.
Mitte no. xx
Sig: (as below)

May also be prescribed by listing ingredients as follows:

	Metric	*Apoth.*
Acetanilidi	4.0 Gm.	3 i
Acid. Acetylsalicylici	4.0 Gm.	3 i
Sod. Bromidi	6.0 Gm.	3 iss
Sod. Citratis	2.6 Gm.	gr. xLv

Ft: cap. no. xx

Sig: One capsule with a glass of water. Repeat in an hour if necessary.

℞ AN ANALGESIC AND HYPNOTIC

Prescription No. 8. Capsules of Barbital and Aspirin N. J. F.

May be prescribed by title as follows:

Capsularum Barbitali et Acidi Acetylsalicylici, N. J. F.

Mitte no. xx

Sig: (as below)

May also be prescribed by listing ingredients as follows:

	Metric	*Apoth.*
Barbitali	4 Gm.	3 i
Acidi Acetylsalicylici	4 Gm.	3 i

Ft: cap. no xx

Sig: One capsule when necessary for pain.

℞ AN ANALGESIC COMBINATION

Prescription No. 9 Compound Aspirin Capsules N. J. F.

May be prescribed by title as follows:

Capsularum Acidi Acetylsalicylici Co., N. J. F.
Mitte no. xx
Sig: (as below)

May also be prescribed by listing ingredients as follows:

	Metric	*Apoth.*
Acidi Acetylsalicylici	3.25 Gm.	gr. L
Acetophenetidini	3.25 Gm.	gr. L
Caffeinae	0.65 Gm.	gr. x

Ft: cap. no. xx

Sig: One or two capsules as directed.

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RESCRIPTIONS

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MMITTEE ON RELATIONS

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L, M.D., Merchantville
M.D., Atlantic City
N, M.D., Union City
, M.D., Passaic

℞ A SEDATIVE

Prescription No. 10 — **Compound Elixir Ammonium Valerianate N. J. F.**

May be prescribed by title as follows:

	Metric	*Apoth.*
Elix. Ammon. Valerianatis Co., N. J. F..	60 cc.	ʒ ii

Sig: (as below)

May also be prescribed by listing ingredients as follows:

	Metric	*Apoth.*
Sod. Bromidi	10 Gm.	gr. 150
Elix. Ammonii Valerianatis N. F., q.s...	60 cc.	ʒ ii

Sig: One teaspoonful diluted with water three times a day after meals.

℞ AN ALKALIZING COUGH SEDATIVE

Prescription No. 11 — **Compound Syrup of Potassium Guaiacolsulfonate N. J. F.**

May be prescribed by title as follows:

	Metric	*Apoth.*
Syr. Pot. Guaiacolsulfonatis Co., N. J. F..	120 cc.	ʒ iv

Sig: (as below)

May also be prescribed by listing ingredients as follows:

	Metric	*Apoth.*
Potassii Guaiacolsulfonatis	5.00 Gm.	gr. Lxxx
Sod. Citratis	3.60 Gm.	ʒ i
Acidi Citrici	1.20 Gm.	gr. xx
Spiritus Chloroformi	3.00 cc.	m xLviii
Tr. Limonis	0.36 cc.	m v
Syr. Pruni Virg.		
Syr. Tolu.		
Elix. Taraxaci Co. āā, q.s.	120.00 cc.	ʒ iv

Sig: One or two teaspoonfulls as directed.

This prescription contains the same ingredients as a well-known proprietary.

℞ A COUGH EXPECTORANT

Prescription No. 12 — **Compound Syrup of Ammonium Chloride N. J. F.**

May be prescribed by title as follows:

	Metric	*Apoth.*
Syr. Ammonii Chloridi Co., N. J. F.	120 cc.	ʒ iv

Sig: (as below)

May also be prescribed by listing ingredients as follows:

	Metric.	*Apoth.*
Potassii Guaiacolsulfonatis	2.40 Gm.	gr. xL
Ammonii Chloridi	2.00 Gm.	ʒ ss
Antimonii et Pot. Tart.	0.0156 Gm.	gr. ¼
Syr. Cerasi	30.00 cc.	ʒ i
Syr. Pini Alb. Comp., q.s.	120.00 cc.	ʒ iv

Sig: One or two teaspoonfulls as directed.

PRESIDENT'S ANNOUNCEMENT—No. 8

THE MEDICAL PROFESSION LEADS

By Spencer T. Snedecor, M.D., Hackensack, N. J.

This series began with the issue of July 1936

Many new groups of workers are concerned today in health and medical service. While but a few decades ago the doctor was usually the only one in his community dealing with health problems, we now have in addition to the physician, the hospital groups, public health agencies, nursing services, and welfare organizations,—all deeply and sincerely participating in an effort to provide the people with efficient medical care.

It was quite natural for these groups to come to believe that the doctors were somewhat outmoded in their practice, and were so steeped in hide-bound ethics and tradition that it was up to others to devise better ways and means to meet modern needs. For instance, the majority of the Committee on the Costs of Medical Care swung to the idea of building a community medical service about the hospital. Many public health departments have leaned to the thought of providing curative as well as preventive medical care, and the social workers too have envisioned schemes of planned and compulsory service.

Slowly the medical profession has aroused itself to an appreciation of these modern demands, and also to the threats of directing and controlling the actual practice of medicine. Now we are awakened to our responsibilities, and we are ready and organized to deliver those services that should be expected of us.

The program of our Society as published month by month in this Journal outlines our current activities in every phase of medical problems. It reflects our contacts and cooperation with all the public health and welfare agencies; and most of all, we have shown in a practical way how medical service can best be delivered to all the people.

Medical care of indigents in hospitals should be provided by revising clinic and ward services so as to secure a better selection of patients, and to prevent over-loading. Their care in the home can best be given by a plan similar to our old Emergency Relief agreement, in which the municipality pays a reasonable fee to the doctor of the patient's choice, and not to a so-called "city" or "poor" physician.

For the people of the low-wage groups we are recommending *hospital insurance,* and we are setting up medical service bureaus to adjust the medical fees within the ability of the patient to pay on a reasonable installment basis. In the field of preventive medicine we are striving to make "Each doctor's office a health center" for preventable disease.

True, our plan does not include health or sickness insurance, for we see no advantage in that to either the people or the physician. We do not believe in wholesale service to the indigent like that of the present clinic set-up; nor in the city physician, because each system delivers a poor quality of medical service. Nor do we accept the mass method of preventive service, except in so far as it is necessary to reach those who cannot be brought to the physician's office.

The promulgation of this creed is our responsibility. In each County Society we must make it known through our Public Relations Committees. Through the other active committees in the county societies we must carry out our contacts and associations with civic groups and the people. As practicing physicians we must render a modern type of medical service, placing special emphasis upon the preventive and early diagnostic side of our practice.

The other collateral agencies, such as hospitals and health departments, and the accessory services, such as the nursing organizations, the Tuberculosis League and others, have their share in the general plan. But we are all seeing more clearly how each can assist the other, and what the scope of function of each group is. Looking at the whole plan of providing health and medical service, we arrive at the inevitable conclusion that the physician is not only the *key* person in rendering it, but also that he must lead and show the way to the proper control and expansion of these services.

We urge each County and State Committee to perform the tasks which are before it; and each fellow member to accept his part in carrying out his creed of modern medical practice.

WELFARE COMMITTEE—JANUARY, 1937

The Welfare Committee of The Medical Society of New Jersey met in the Stacy-Trent Hotel, Trenton, N. J., at two o'clock on the afternoon of Sunday, January 17, 1937, with the Chairman, Dr. Hilton S. Read, of Atlantic City, presiding, and forty members present, as follows: Drs. Read, Shivers, Wilson, Stokes, Lewis, Sewall, Teimer, Levy, Zehnder, Cardwell, Orton, Ulmer, Pollak, Pyle, Haggerty, Stone, Haywood, Kler, Nichols, Clayton, Costello, Sherman, MacMillan, Field, Murphy, Mitchell, Snedecor, Morrison, D'Arcy, McGuire, Quigley, Herrman, North, Carrington, Hawkes. Sommer, Walker, Watts, Overton, and Wilkes.

The principal item on the program was a discussion of the activities of the Sub-Committees. through whom the greater part of the work of the Welfare Committee is done.

PUBLIC RELATIONS

Dr. J. H. Kler, Chairman of the Sub-Committee on Public Relations, stated that the principle of the organization of the committee was that the State Committee should deal with lay health groups whose field is State-wide; while a *County* Committee should deal with similar groups whose fields are local.

Speakers' Bureaus. The State Committee is developing a Speakers' Bureau as one of its major activities, and will supply speakers to State-wide groups; but will refer requests for speakers before a local organization to the county society. The State Committee will assist the local committee on request; but it advises that the local committees enhance their own prestige by acting on their own initiative.

Package Library. The committee plans to make use of the services that are offered by the American Medical Association in supplying copies of articles and addresses on health subjects adapted to lay audiences, and newspaper articles, and radio broadcasts.

Newspaper Publicity. Dr. Kler outlined the kinds of medical subjects which newspapers use, and divided them into two classes:

1. Impersonal scientific descriptions of new methods of diagnosis and treatment, and prophecies of what they may be expected to accomplish. Included in this group are the "Do you know" items, such as. "The gorilla is the only lower animal that picks its teeth." The committee has not planned anything definite along this line.

2. Personal news of medical meetings, and of activities promoted by medical societies, both State and local. The committee is encouraging the county societies to develop this branch of publicity, and to build the story around local medical leaders, for this is the newspaper way of reporting news, and physicians must adopt it in order to have their activities printed.

Dr. Kler announced methods for reporting the Annual Meeting in Atlantic City on April 27-29, amplifying the service of the Editor in previous years in maintaining a press room where correspondents may be received, and items prepared for them.

Health Weeks. The committee proposes to encourage county societies to hold "Health Weeks", similar to that of the Middlesex County Society on April 13-18, 1936 (Journal, May 1936, page 311), and the coöperation of the Cumberland County Medical Society in the historical exhibit on the 250th anniversary of the founding of Bridgeton (Journal, May 1936, page 319).

Dr. W. G. Herrman, President-Elect, called attention to the unfortunate results of improper information and suggested that it be the regular policy of the committee to edit the proposed addresses of physicians addressing lay audiences. The members of the President's Cabinet of the State Society had agreed upon an outline which each officer followed in his addresses to the county societies, thereby insuring a uniformity of statement and action.

Dr. Wilkes, Executive Officer, spoke on evaluating methods of approach in publicity. Criticisms of the attitude of a lay organization arouse its antagonism; on the other hand, starting an address or newspaper article by agreeing in some details with a speaker on the opposition, invites good will at the outset. Dr. Carrington, Vice-President, suggested that members inform Chairman Kler whenever they get a new idea regarding a subject or method of publicity. Dr. Quigley, Chairman of the Board of Trustees, called attention to the two great groups of laymen to be reached by medical publicity:

1. Organizations, many of whom maintain their own facilities for publicity.

2. The unorganized laity, who are reached by newspapers, radio, and popular lecturers.

Dr. Quigley asked what is the relative value of these two groups as the recipients of medical publicity.

Dr. Kler replied that Dr. Bauer, Director, Bureau of Health and Public Instruction of the A. M. A., places the radio first in value among the means of reaching the unorganized body of people; but Dr. Kler said that at present the Public Relations Committee would con-

centrate the greater part of its efforts on the organized lay groups, such as the Nursing and the Parent-Teacher organizations. "We shall seek invitations to their meetings, and we shall invite them to ours", said Dr. Kler in closing.

MEDICAL PRACTICE

Dr. Thomas K. Lewis, Chairman of the Sub-Committee on Medical Practice, reported that the committee is engaged in investigations along original lines.

In Workmen's Compensation, Chairman, Dr. J. Irving Fort, and in the Medical Care of the Indigent, Dr. C. H. Schlichter, Chairman, each reported that further progress will depend upon the action which will be taken by the Legislature.

Dr. R. L. Sharp, Camden, reported that the Committee on Hospital Relationships is proceeding with the tabulation of the answers to the sixty questions on the questionnaire which had been sent to every hospital; and that no report could be made until the summaries are completed.

Dr. C. I. Ulmer, Chairman on Pharmaceutical Problems, reported on the cards of prescriptions which appear in The Journal in alternate months.

LEGISLATION

Dr. B. S. Pollak, Chairman of the Sub-Committee on Legislation, spoke of the probable effect of the control of the two branches of the Legislature by opposite political parties. Two new bills on the examination of school teachers for tuberculosis, and the blood tests for legitimacy of children, may be introduced.

PUBLIC HEALTH

Dr. Stanley Nichols, Chairman, Sub-Committee on Public Health, reported on the Baby-Keep-Well Stations to be conducted by physicians approved by the county societies. Eight appointments have now been made.

Forms for examining children of the preschool age were described by Dr. Nichols, with the objective to continue the series through the years of school life and even into adult life, with the expectation that a person approaching mature life will have a complete record of his health from birth.

VENEREAL DISEASE CONTROL

Dr. Nichols described the proceedings of the Conference on Venereal Diseases called by Dr. Parran, Surgeon General of the United States Public Health Service, during the holiday week. Dr. Casselman presented the New Jersey plan to the Section on Physicians, and the Integration of Doctors. There was considerable discussion over Dr. Casselman's plan that the medical societies of the State and counties should be recognized as leaders in movements for the control of venereal diseases. Dr. Parran said that the New Jersey plan was one of the most valuable features of the conference.

CANCER CONTROL

Dr. Henry B. Orton, Chairman of the Advisory Committee on Cancer Control, reported that the committee had completed the survey of New Jersey's facilities for the diagnosis and treatment of cancer. He submitted a report and a map showing the location of each hospital that has a cancer department, and a table of the service given by each (p. 112).

HANDBOOK OF PUBLIC HEALTH PROCEDURES

Dr. Nichols reported that the proposed Handbook of Public Health Procedures is now nearly ready for the printer. It will consist of eleven chapters, dealing with the subjects assigned to the seven advisory committees, and will be issued as a supplement to The Journal,—probably the issue of March.

SUMMARY

Dr. S. T. Snedecor, President of The Medical Society of New Jersey, expressed the opinion that this meeting of the Welfare Committee has been one of the best that has been held, because it reported the completion of several lines of work and the accomplishment of definitely planned objectives. He reviewed the developments of the propaganda for health insurance, and predicted that a further development of the medical activities in New Jersey and their adoption in other states will forestall radical action by Congress.

REFERENCE COURSE IN OBSTETRICS

All physicians wishing to take a refresher course in obstetrics at Margaret Hague Maternity Hospital are requested to send in their applications promptly to the chairman, Arthur W. Bingham, M.D., 144 S. Harrison Street, East Orange, N. J. For details, refer to page 716, December State Journal.

SHOULD MEDICAL CARE BE A SOCIAL RESPONSIBILITY?

Abstract of an address by Dr. J. B. Morrison, Secretary of The Medical Society of New Jersey.

At the outset of his address, Dr. Morrison sums up his conclusions in the statement:

"The *indigent* should be cared for by the State. All others should pay their bills,—the bills to those in the lower brackets of income to be adjusted by the physician."

It has been demonstrated that, in countries where medical care is a function of the State, epidemics of communicable diseases are controlled with far more difficulty than in the United States where every doctor is an unofficial health officer and is deeply interested in the study, control and prevention of communicable diseases. Under the socialized system, the practice of medicine would be reduced to a *trade*, affording a bare living to the doctor,—and the public would suffer still more than the physicians.

The burden of proof is upon the proponents of socialized medicine to show that their system makes people happier and healthier than the people of America under our present form of medical service.

In America, the Family Doctor is a trusted adviser in health; as in sickness. Parents consider him as a trusted councilor and friend, and consult him about their children's education, avocations and vocations, and later about their marriage and home life. Fifty times a year, every doctor is consulted about things not intimately connected with medicine for which no charge is made. There is a great movement in America to change all this, and to make the Family Doctor an employee of the government, giving service on an entirely impersonal basis.

The European system of medical service to those of low incomes is called "Health Insurance". In reality, the government does not *insure health*,—it simply provides inadequate medical service *after sickness develops*. It does not *prevent* sickness.

In the European system the doctor must often spend more time in making out sick reports than in treatment. The system has resulted in a rush to secure certificates of sickness from the doctor, so the number of so-called patients that he is compelled to see is five times the normal number of really sick patients.

In America the laborer "wants what he wants, and when he wants it".

The system stifles the ambition of the doctor to improve himself by study.

In New Jersey the Medical Profession besieged the Legislature for twenty years to secure the care of the insane, the establishment of a State Department of Health,—not for its own benefit, but for the good of the people. Where would this incentive be under a socialized system? Under a socialized system, the medical schools, the great medical centers, and organizations of physicians would have little power. The system would be managed by politicians who know nothing about medical service, or its administration.

Every year, a thousand European physicians of the better class are seeking admission to America. The reputation of the European universities as medical teachers has waned, and few American physicians of better class seek graduate courses in European universities, for the instruction is on a commercialized basis.

The group of promotors who are urging socialized medicine in America are not affected by the plan which they propose as hirelings. The appeal of the American Association for Social Security is to class prejudice rather than to organized medicine.

For the benefit of the people as well as themselves, practicing physicians in New Jersey should bring these facts to the attention of their patients and the people.

ORGANIZED CANCER CONTROL IN NEW JERSEY

THE REPORT OF THE ADVISORY COMMITTEE ON CANCER CONTROL TO THE WELFARE COMMITTEE OF THE MEDICAL SOCIETY OF NEW JERSEY, ON JANUARY 17, 1937

By HENRY B. ORTON, M.D., Chairman

The Committee on the Control of Cancer of The Medical Society of New Jersey has completed its survey of the State in relation to the facilities available for the diagnosis and treatment of cancer and submits the following report.

Taking the State as a unit, a questionnaire, which is part of this report, was mailed to 171 hospitals and nursing homes throughout the State. The figures to the left of the column are the key numbers corresponding to the hospital to which it was sent. Of the 171 ques-

tionnaires sent, 163 replies were received. Eight hospitals made no reply after three communications had been sent them.

(The complete report is filed in the Executive Offices. A summary of the answers to the more essential questions is printed as an appendix to this report.—*Editor's Note.*)

In answer to the first question, i. e., "Do you have a cancer clinic connected with your hospital?", twenty answered in the affirmative, and 142 in the negative.

Second question, "Do you have a staff organization?", twenty-one hospitals answered in the affirmative, and 141 in the negative.

Third question, "How much radium have you available?", only seventeen hospitals had radium of their own, ranging from twenty-three milligrams, to 335 milligrams. At this point I might add that in eight hospitals the radium used in connection with the treatment was privately owned by physicians on the staff.

In answyer to the fourth question, "Have you a modern deep x-ray machine?", thirty hospitals said they had, and 132 hospitals did not have a modern deep x-ray machine.

Fifth question, "Do you admit indigent incurable cancer patients to the wards or rooms in your hospital?", sixty-five hospitals admitted this class of patient, some reluctantly; and ninety-seven did not admit them.

Sixth question, "If you do not admit patients mentioned in the above question, what arrangements do you make for the care of the indigent incurable cancer patient?", thirty-seven referred them to proper hospitals where facilities were available; twenty-four hospitals referred them out of the State either to New York or Pennsylvania; and five referred their patients to the Social Service Department for proper settlement.

Yet in answer to the question, "How many cancer cases of all forms did you have in your hospital during the year?", the hospitals of New Jersey reported that they had had 6080 cases of cancer during 1935.

In answer to the last question, we find only twenty-four hospitals have an organized movement for the establishment of a tumor or cancer clinic.

As we analyzed the above figures, we find that fifty-six hospitals out of the 163 replies received were special hospitals, such as tuberculosis, mental, etc., that do not admit, nor do they have any cancer cases. In addition, we have also deducted the twenty-four special hospitals that do not have any facilities to treat cancer, since they do not accept any cancer patients; however, they attempt to take care of the patient who may develop cancer while in their institution. This necessarily lowers the number of hospitals participating in the care or treatment of cancer materially, or to eighty-three.

Taking the eighty-three hospitals as our working basis, twenty stated they had a cancer clinic; twenty-one hospitals stated they had a staff organization; seventeen hospitals had radium; thirty hospitals had deep x-ray machines; and in eight hospitals the radium was privately owned by members of the staff; and sixty-five admitted indigent cases.

Notwithstanding the fact that sixty-five hospitals out of eighty-three admitted indigent patients, thirty-seven of which did not accept them, the next question, "What arrangements do you make for the indigent patient?", thirty-seven referred them to other hospitals; twenty-four out of eighty-three referred the patients out of the state; and five placed them in the care of social service. Yet in 1935 there were 6080 cases of cancer in the hospitals of New Jersey. This represents the summary of the survey in general.

We have also classified these hospitals according to counties, in order to facilitate easy reference for the members of the committee as well as for the physicians interested in cancer in their respective counties.

Accompanying this report is a map of the state with all the hospitals marked thereon according to cancer facilities available in their respective counties. When we look at the map of the entire state we find but eight hospitals completely equipped.

It is needless to say that the cancer situation in New Jersey is far from satisfactory when we consider that twenty-four hospitals out of eighty-three refer their indigent patients to New York and Pennsylvania, and only eight hospitals are fully equipped to care for this type of patient.

In order that we may improve this service for the indigent patient, the committee requests and urges to the fullest measure the wholehearted support of the entire medical profession throughout the state,—not only the physicians interested in cancer, but every physician.

The Committee on the Control
of Cancer
Henry B. Orton, *Chairman*
F. C. McCormack
James H. Rosecrans
John F. Condon
J. H. Kler
Carl Mange
E. E. Downs

HOSPITAL FACILITIES FOR DIAGNOSING AND TREATING CANCER IN NEW JERSEY

A SUMMARY OF THE TABLES CONTAINED IN THE REPORT OF THE COMMITTEE ON CANCER CONTROL

	Cancer Cases 1935	Has a Cancer Clinic	Has a Cancer Staff	Has Radium Milligrams	Has Deep X-Ray Therapy
Atlantic County					
Atlantic City Hospital	284	+	+	150	+
Bergen County					
Englewood Hospital	59		0	0	+
Hackensack Hospital	88	+			
Holy Name Hospital, Teaneck	50	0	0	0	0
Burlington County					
County Hospital, Mt. Holly	0	+	+	0	0
Camden County					
Cooper Hospital	150	0	0	100	+
West Jersey Homeopathic	50	0	0	50	+
Camden County General, Greenloch					
Cumberland County					
Bridgeton Hospital	70	0	0	50	0
Millville Hospital	20	0	0	0	0
Newcomb Hospital, Vineland	14	0	0	0	+
Essex County					
Essex County Hospital, Cedar Grove	6	0	0	0	+
Irvington General Hospital	40	0	0	0	+
Montclair Community Hospital	30	+	+	0	+
Mountainside Hospital, Montclair	120	+	+	209	+
St. Vincent's Hospital, Montclair	20	+	+	0	0
Beth Israel Hospital, Newark	400	+	+	335	+
Newark City Hospital	262	0	0	0	+
Newark Eye and Ear Infirmary	9	+	+	0	0
Newark Memorial Hospital	175	+	+	0	+
Orange Memorial Hospital	84	+	+	100	+
St. Barnabas' Hospital, Newark	196	+	+	Private	0
Gloucester County					
Underwood Hospital, Woodbury	125	0	0	0	–
Hudson County					
Christ Hospital, Jersey City	79	+	+	0	+
Jersey City Hospital	549	+	+	0.8	+
North Hudson Hospital, Weehawken	94	+	+	0	0
Jersey Eye, Ear, Nose and Throat Hospital, Jersey City	10	0	0	23	+
Mercer County					
Mercer Hospital, Trenton	117	0	0	100	0
St. Francis' Hospital, Trenton	103	0	0	110	0
Trenton Municipal Hospital	22	0	0	0	+
Middlesex County					
Middlesex General Hospital, New Brunswick	62	0	0	100	+
Monmouth County					
Hagard Hospital, Long Branch	60	+	+	0	+
Monmouth Memorial Hospital, Long Branch	100	0	0	50	0
Morris County					
Morristown Memorial Hospital, Morristown	24	0	0	0	+
Passaic County					
Beth Israel Hospital, Passaic	25	0	+	0	0
Barnert Memorial Hospital, Paterson	300	+	+	80	0
Paterson General Hospital	285	+	+	150	+
St. Joseph's Hospital, Paterson	140	+	+	100	+

	Cancer Cases 1935	Has a Cancer Clinic	Has a Cancer Staff	Has Radium Milligrams	Has Deep X-Ray Therapy
Somerset County					
Bound Brook Hospital	25	+	+	0	0
Union County					
St. Elizabeth's Hospital, Elizabeth	150	0	0	Private	+
Muhlenberg Hospital, Plainfield	96	0	0	0	+
Totals for State	**4497**	**19**	**19**	**1707**	**26**

NEW JERSEY BRANCH, AMERICAN ACADEMY OF PEDIATRICS

A Dinner Meeting of the New Jersey Fellows of the American Academy of Pediatrics was held at 6 p. m. on Wednesday, December 2nd, 1936, in the Essex House, Newark.

Dr. Stanley Nichols, State Chairman, presided at the business session, at which twenty-four were present.

STANDARDS OF MATERNAL NURSING

Dr. Frederic Lathrop presented the following resolutions, which were adopted:

STANDARD PRACTICES FOR INCREASING MATERNAL NURSING

Before formulating practices for increasing maternal nursing, it is wise to review the basis for the superiority of breast milk over artificial feeding.

1. Breast feeding is simple and easy. There are no bottles to boil, no very intelligent care is necessary, and no complicated apparatus is required.

2. Breast milk is safe. It is pure and sterile with no possibility of contamination.

3. Breast milk is cheap. The mother has it available, and no additional expenditure for food is necessary.

4. Breast milk provides homologous proteins, biologically adapted to the human body.

5. Breast milk supplies certain growth factors. It is biologically efficient in nourishing growing human tissues.

6. Breast milk provides resistance potentialities, whether or not this is in the form of immune bodies, or in the form of a biologically ideal nutriment.

7. Breast milk physically and chemically acts as a transition feeding to develop the intestinal tract to its full digestive capacity in the change from uterine life to a full diet.

8. Morbidity and mortality statistics still show breast milk to be superior to artificial feeding.

9. Colostrum is especially valuable as a source of immune bodies, as a source of easily absorbable nutriment, and in preparation of the digestive tract for milk proteins.

Following are the recommendations for standard hospital practice in the care of the new-born:

1. More confident expectation of successful nursing and persistent encouragement of the mother with the view toward breast feeding, with adequate explanation of the superiority of breast feeding by the obstetrician during the antepartum period.

2. The recommendation that all new-born babies on ward service be placed in charge of a pediatrist when such is available, since pediatrists, more than anyone else, appreciate the value of breast feeding.

3. The initial loss of weight in the first few days of life is to be expected; and this loss of weight should not be an indication for beginning complementary feeding.

4. Stock formulae to be altogether eliminated, since the feeding of the new-born is more successful when individualized. Furthermore, individualized feeding compels active supervision on the part of the attending physician.

5. Cow's milk in the first few days of life may be allergenic.

6. Weighing the baby before and after nursing is to be discouraged, since such a practice is likely to give false ideas of the inadequacy of breast milk because of the physiological variations in the quantity secreted from day to day.

7. No mother to receive a formula on discharge from the hospital, unless absolutely necessary, because, if she has a formula available, she is more apt to use it, and less apt to persist in trying to develop her own breast supply.

8. The baby may need some form of weak carbohydrate solution during the prelacteal period, to avoid dehydration and acidosis.

9. For routine hospital care, the following schedule is recommended:

Babies to be placed to breast six hours after birth.

For the first twenty-four hours, nurse at four-hour intervals, with five-minute feedings on alternate breasts.

For the second twenty-four hours, nurse at four-hour intervals with ten-minute nursing.

Thereafter, nurse for twenty minutes, using the four-hour interval for infants weighing over seven pounds, and three-hour interval for infants weighing less than seven pounds.

For the first few days boiled sugar-water, or hydrating solution of lactose and sodium citrate, to be given after nursing.

Complementary feeding only in weak infants, or with more than 10 per cent loss in weight.

Complete emptying of the breasts by mechanical breast pump, if baby does not nurse vigorously.

Reassurance to the mother that the slight loss of weight during the hospital period is often regained rapidly at home.

Confident encouragement to the mother that the supply of breast milk will be increased, due to favorable influence of home surroundings and return to normal living conditions.

Dr. Brown moved that the Academy adopt these resolutions as read, and they be mimeographed for distribution to interested agencies in the State. Seconded and unanimously carried.

MEMORIAL TO DR. STERN

Dr. Nichols announced the death of Dr. Arthur Stern. Dr. Stern's death was the first since the organization of the New Jersey Branch of the American Academy of Pediatrics. The Chairman was requested to appoint a committee to draw up suitable resolutions on Dr. Stern's death to be sent to his family.

SPEAKERS ON CHILD HEALTH

Dr. Nichols appointed Dr. Stewart as Chairman of a committee to assist the State Medical Society Public Relations Committee to secure speakers on Child Health.

Dr. Nichols turned the chair over to Dr. Wilkes, who presided for the rest of the evening.

ADDRESS BY DR. T. K. LEWIS

Dr. Wilkes presented the first speaker, Dr. Thomas K. Lewis of Camden, Chairman of the State Society Sub-Committee on Medical Practice. Dr. Lewis, by request, spoke on the "Future of Medical Practice". (See Journal, November, 1936, page 631.)

ADDRESS BY DR. STANLEY NICHOLS

The first speaker, on the subject "The Opportunities and Responsibilities of the New Jersey Fellows in the American Academy of Pediatrics", was Dr. Nichols, Chairman of the New Jersey Academy.

Dr. Nichols stressed the fact that *every* physician's office in New Jersey should be a health center for the practice of preventive medicine. The pediatrician is the one to lead in the development of the program, as 1937 is going to be a crucial year for the medical profession.

Our responsibilities as the New Jersey members of the American Academy of Pediatrics divide as follows:

1. To the pediatricians themselves.
2. To the State Society.
3. To the State Department of Health.
4. To the public.

Our *first* object is improvement of child health through periodic supervision and adequate pediatric knowledge.

We should lead the way in the rehabilitation of the family physician for service to *mothers*, infants, and children of the pre-school and school ages. We should always maintain high quality service to these groups which are the basis of pediatric practice.

The future of pediatric practice will have to be settled on the basis of economic levels of income.

1. The low-wage group we will take care of as we do now.
2. The middle class group we will devise a system of adjusting fees.

ADDRESS BY DR. HILTON S. READ

The second speaker on the subject was Dr. Hilton S. Read, Chairman of the Welfare Committee of the State Society.

Dr. Read emphasized the fact that it is the *"politicalization* of medicine that we fear; and in order to avoid this, we must show the government that the profession is willing and able to care for the American people in an American way. The pediatricians must preserve this right to practice along the American trend. The pediatrician is the best qualified to advise on preventive medicine. We must have a united effort in the distribution of medical care and the cost thereof.

ADDRESS BY DR. JULIUS LEVY

Dr. Julius Levy, consultant in child health to the State Department of Health, the third speaker on this topic, stated that we must forget we are individuals, and also think as a group. As individuals, our responsibility is merely to give the best service we can. As a group, it is our definite responsibility to give the full value of our knowledge as pediatricians and make this knowledge available to the rest of the physicians. This knowledge must be given to the people as well. No matter how extensive your practice is, you are not going to reach *all* the babies born during the year. The pediatric group have the opportunity to concern themselves in a constructive way with problems which they are *best fitted* to deal with, and what the public departments are *forced* to deal with. The pediatricians should study prenatal deportment, high deaths from premature births, feeding, and do *more* than pass resolutions. The physicians of New Jersey have a splendid *opportunity* to work out their own problems. No other state has such coördination between the public and private agencies, and each is willing to be guided by the other.

The meeting adjourned at 10 p. m.

LeRoy A. Wilkes, *Secretary.*

SCIENTIFIC EXHIBITS AT THE ANNUAL MEETING, 1936

ARTICLE NUMBER THREE

By Asher Yaguda, M.D., Newark, N. J.
Chairman, Committee on Scientific Exhibits



Photograph Number 6.—Primary Carcinoma of the Lung. The Lahey Clinic, Boston, Mass.

This exhibit calls attention to the following pertinent facts about carcinoma of the lung:

1. In the majority of cases, primary carcinoma of the lung originates in the stem bronchi (80 per cent).
2. The early symptom is persistent cough and often hemoptysis.
3. The stem bronchus lesion is visible bronchoscopically; therefore, early diagnosis depends upon the use of this diagnostic procedure.
4. The roentgenogram fails to be significant until the lesion is large enough to occlude a bronchus.
5. Reproductions of roentgenograms of various cases were shown before and after pneumonectomy.
6. A summary of the results of pneumonectomy was given. There were eight patients with five operative recoveries. Photographs of two patients were shown, one taken two years; and one, one and a half years after operation.
7. The technic of the operation was illustrated by colored transilluminated drawings.



Photograph No. 10.—Diagnosis and Treatment of Peripheral Vascular Diseases. By Dr. Louis G. Herrmann, Department of Surgery, University of Cincinnati, Cincinnati, Ohio.

The accurate diagnosis of arterial diseases is of paramount importance in outlining proper therapy. A simple means of differentiating between spastic and occlusive arterial diseases is presented in the exhibit. When the arterial insufficiency is essentially the result of organic disease of the arteries, all efforts must be directed toward the development of an adequate arterial circulation through the existing collateral pathways. The alternation of the environmental pressure in the form of passive vascular exercises offers the most physiologic means of bringing about the greatest increase in the arterial circulation with the least damage to the delicate tissues of the affected extremity. The historical background for this method of treatment was presented in detail.



Photograph Number 11.—Gross Pathology. By Dr. A. R. Casilli, Elizabeth, N. J.

There are two principal advantages to be derived from a hospital museum. Of these two, education is the more important. The educational benefits are widespread, reaching the hospital medical staff, interne staff, nursing department, and even to a limited extent, the lay public.

The educational opportunities afforded the medical staff by a hospital museum are obvious. Few physicians could spare the time to be present at every operation and autopsy, in order to inspect the gross pathology found. The museum presents noteworthy gross pathology more clearly than when seen in situ at autopsy or operation. At clinical meetings museum specimens form an invaluable adjunct in the verbal descriptions of a case. Possibly a more practical assistance is that rendered the surgeon by an adequate hospital museum. A museum acquaintance with breast tumors, for example, will enable him to recognize more readily breast cancer grossly at the time of operation.

The advantage of a hospital museum to the nursing department are likewise readily appreciated. Anatomy and pathology become more realistic and intelligible to student nurses when lectures in these difficult subjects are illustrated by museum specimens.

The advantages to the lay public seem minimal; however, in any community there are numerous, semi-scientific lectures given by doctors to members of various organizations such as service clubs, women's clubs, and parent and teacher groups, for the health education of the community in general. Museum specimens are more informing to the public than an hour of medical description.

The second advantage to be gained from a hospital museum is rather more intangible. It records for the future the medical history of the hospital as does no other department. It is the visual record room of hospital events and progress. It elevates the laboratory from being merely a routine, urinalysis-blood count shop.

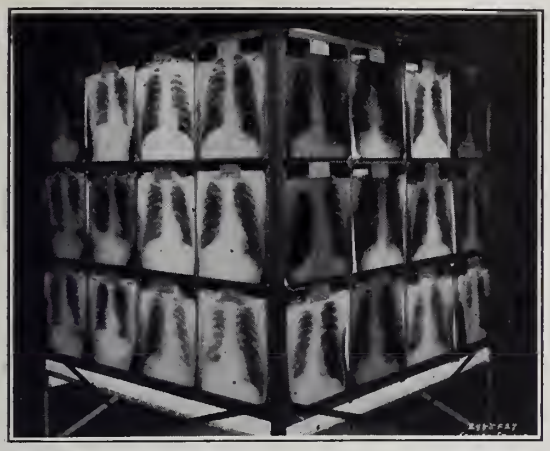
The selection of specimens for a museum should depend on two factors; volume and variety. These two desiderata are not difficult of accomplishment if the pathological staff is museum-minded. In presenting over two hundred varied specimens we endeavored to fulfill these requirements. To enumerate the specimens shown in this exhibit would be tedious; nevertheless, in order to indicate a few museum possibilities the following are included in our exhibit: Heart specimens demonstrating coronary occlusion, bacterial endocarditis, valvular stenosis, congenital anomalies; lungs showing types of pneumonia, tuberculosis, cancers and abscesses; digestive tract lesions such as tumors of the tongue, esophagus, stomach, small intestine, cecum, colon, and rectum, and ulcers, lymphoid hyperplasias, volvulus, and intussusception; tumors of the genito-urinary system. I have found that there is never monotony in specimens of similar lesions. Though the difference may be very small, it is sufficient to individualize the mount.

The preservation and mounting of specimens is of utmost importance. Neatness and artistry should be kept constantly in mind. The ideal method, in most instances, is the preservation of the specimen in natural color. This is satisfactorily achieved by the Kaiserling or other time-tested methods. In the early days of museum work, specimens were "pickled" to an unnatural whiteness in formaldehyde. This procedure is to be avoided, for specimens so preserved have little practical value, merely occupying space.

One important point is to mount, whenever feasible, the sequence of pathology in one jar to form a composite picture. There were several illustrations of this feature in the present exhibit. One jar contained infected uterus, acute vegetations of the mitral valve, embolic infarctions of the spleen, kidney and small intestine in a case of uterine sepsis.

In our exhibit we refrain from showing photomicrographs. We believe these do not convey much information to the general medical public, and since these pictures can only represent one field from the whole section, little indeed is imparted to the experienced pathologist. In addition, pictures may distract attention from the gross specimen.

In conclusion, it is my firm belief that every hospital should establish and maintain a museum of gross pathology.



Photograph Number 20.—Progress of Tuberculosis Lesions under Compression Therapy. New Jersey Sanatorium for Tuberculosis, Glen Gardner, N. J.

This exhibit represents the efficacy of some of the various types of collapse therapy gaining rapidly in use in this country since about 1914. Probably the most popular and widely used is collapse therapy brought about by the induction of an artificial pneumothorax, produced by allowing atmospheric air or some of the other less irritating gases to flow into the pleural cavity. The treatment is given under aseptic technic at intervals of a few days, until later, when the treatments are gradually lengthened and continued for varying periods of time—some two to four years—after which the diseased lung is allowed to expand. There will, however, be a few cases in which the lung, due to a thickened pleura or some other reason, will fail to expand, when more radical measures must be taken.

General indications for artificial pneumothorax are: Acute unilateral lesions where time is a factor; repeated hemoptyses; cavity, either with or without copious expectoration; acute pleurisy; massive pleural effusions. It acts by putting at rest the venous and lymphatic circulation of the lung and also by limiting pulmonary movements.

Bilateral and selective types of collapse are indicated by their names, the first being available in bilateral or upper chest lesions when too much lung tissue is not involved. Selective collapse is that type in which the injected gas collects or settles immediately over the lesion and fails to bring about a collapse of the non-diseased part of the lung—a very valued procedure when secured.

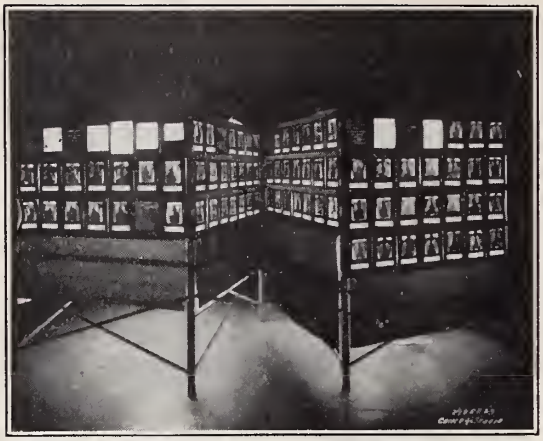
Phrenic interruption, partial or complete, is a removal of a part or whole of the phrenic nerve of one side, through a small incision just above the clavicle and on the side of the lung lesion; this brings about a paralysis with, in most cases, an elevation of the hemi-diaphragm, and in some cases, particularly in small or moderate sized cavities surrounded by fairly good lung tissue or suspended in long, broad adhesions encountered in pneumothorax, a closure. Some surgeons also suggest a severing of the phrenic nerve of each patient about to be discharged when under collapse treatment by artificial pneumothorax, arguing that thereafter fewer refills are necessary and, secondly, that the collapsed lung will not so soon expand.

Other schemes for bringing about collapse are: (a) Plumbage, or the paraffin pack; (b) the extrapleural pneumolysis; (c) intercostal nerve neurectomy, and thoracoplasty. The thoracoplasty operation is constantly growing in popularity. Briefly, it purposes the removal of a number of ribs usually from the apex downward at the rate of three at each operation, and if no complications develop, at about ten-day intervals. This operation, however, is not usually done if one or more of the lesser types will suffice, since it brings about a permanent collapse of the lung of the affected side; and should a later disease be encountered but little could be done.

Early in the use of collapse therapy it was thought that about two per cent of the patients would be eligible, since, it was argued, there must be one good lung. We have found, however, that even a bilateral thoracoplasty can be done, if the involvement is not too great.

At Glen Gardner, approximately 60 per cent of our adult patients received some type of collapse therapy. This is so, I believe, in the case of most other sanatoria of New Jersey. Should all of our institutions treat yearly 6000 patients, about 3600 would secure some type of collapse therapy with the disappearance of tubercle bacilli in approximately 60 per cent, or 2160. Under the old scheme of sanatorium rest treatment, we for years never attained disappearance of tubercle bacilli in excess of eight or ten per cent. It is easy, therefore, to see that, from an epidemiological standpoint alone, there is a great gain, since increased disappearance of tubercle bacilli means fewer infected patients.

It should also be noted that the introduction of these types of collapse therapy are surgical rather than medical procedures, and in proportion as they become popularized or intensified, our sanatoria will need (a) additions to staff; and (b) additions or renovations of plant, rendering the sanatorium an institution of the nature of a general hospital.



Photograph Number 14.—Bilateral Collapse Therapy in Pulmonary Tuberculosis. By Dr. B. P. Potter, Secaucus, N. J.

Individuals presenting bilateral tuberculosis with cavitation have generally been looked upon as having a disease with a poor prognosis. While in the main this is true, it has been shown by scattered clinics in this country and abroad that by appropriate collapse therapy measures opportunely applied the lives of many can be prolonged under ambulatory conditions and that in an appreciable number the prognosis becomes as good as in the favorable unilateral cases.

This study comprises a group of eighty-nine patients observed during a period of five years. They comprise individuals who showed roentgenographic evidence of exudative or mixed cavernous lesions in both lungs, the upper lobe being affected in the vast majority. In each the sputum was positive and in all the tuberculosis was considered active both clinically and roentgenologically.

In about 36 per cent an effective collapse was attained by the simple procedure of artificial pneumothorax. Still more important is the fact that of this effective group only one is dead as compared with twenty-eight dead in the ineffective group. When simple supplementary procedures such as phrenicotomy are considered, the number of effective collapses becomes materially increased. Various other combinations of collapse measures have been used, such as pneumothorax on one side and phrenicotomy on the contralateral side, alternating bilateral phrenicotomy and thoracoplasty on one side in the presence of an effective pneumothorax on the opposite. While bilateral thoracoplasty has proved successful in a few cases in the hands of Coryllos, our attempts have failed to materialize.

As to "The Effects of Pleurisy with Effusion on Tuberculosis", the following may be said:

Historically: For a long time pneumothorax workers noted in occasional cases the collapse of the cavity after a spontaneous effusion had developed. The wet pleurisy apparently serves two purposes:

1. To stiffen the mediastinum.
2. To aid in the collapse of cavities either having thick walls or in some instances held out by adhesions not suitable for cauterization.

Oleothorax was first introduced by Bernou in 1922 and its function in the fixation of the mediastinum stressed by the Matsons in 1932. Its use as an aid in the collapse of cavities in the presence of a stable mediastinum was mentioned for the first time by one of us (Potter) in 1935. This procedure was applied in a total of fifty-four cases in the interval between January, 1932, and December 31, 1935. In roughly 60 per cent complete fixation of the mediastinal structures was obtained, while in the remainder various degrees of partial fixation took place following the induction of an artificial effusion.

Various irritants have been used, such as mineral oil, two and five per cent gomenol in paraffin oil, seven per cent saline solution, and olive oil. It has been found that mineral oil is the least irritating.

It is not necessary at this time to go into details as to the technic. The most important thing is the principle upon which this procedure is based. Simply expressed, it is found that after the introduction of oil into the pleural cavity a pleuritis with effusion develops which results after a period of several weeks in a fixation of the mediastinal structures so that when pneumothorax is finally resumed the stable mediastinum serves as another fixed point to that already presented by the thoracic cage. Under such conditions, it is possible to obtain an effective collapse in individuals in whom prior to fixation of the mediastinum this could not be established. In the presence of an already fixed mediastinum, this procedure may be applied in a very selected group of cases. Under such circumstances, it is believed that the mechanism of closure of cavity resembles in every respect the spontaneous closure of such lesions following the appearance of an effusion attending artificial pneumothorax. The process is one of more or less rapid development of unaeration of lung tissue, particularly the cavernous-bearing area, easily demonstrable on the roentgenogram with either immediate disappearance of the cavity or subsequent obliteration with the continuation of pneumothorax.

THE MEDICAL-DENTAL SERVICE BUREAU, INC., NEWARK, N. J. FIRST ANNUAL REPORT

The first birthday of the Medical-Dental Service Bureau of Essex County was celebrated on December 31st, 1936. What has been the actual experience of this project that was launched just a year ago? Has it been a success or a failure? Has it accomplished all that was predicted for it?

The Board of Trustees believes that it has been successful beyond expectations. During the year the Bureau has written business amounting to $143,000. This is divided into $68,854 for physicians, $9,868 for dentists, and $64,544 for hospitals.

Actual disbursements to the professional members have been $61,398. Of this, $27,802 went to physicians, $5,302 to dentists, and $28,-294 to hospitals. These amounts are net proceeds to the professional members after the Bureau's fee of 10 per cent has been deducted.

The operating income was $7,718.43, and the operating expense $10,560.01, leaving a deficit for the period of $2,841.58. This deficit has, of course, been made up from the capital funds subscribed by the Medical and Dental Societies of the county to start the organization.

Nearly 3,000 patients have been handled by the Bureau, and over 400 physicians and dentists have used its facilities. All of the general hospitals in the county, with one exception, permit cases to be budgeted through the organization.

Members of the board of trustees have been rather successful in selling to their colleagues the unpopular notion that the ten per cent fee retained by the Bureau doesn't seem enough, according to the best business tradition, to cover the operating expenses of the organization, collect all old bills, advance money, and set up a reserve to pay "catastrophic" accounts in full.

Acting constructively, the Medical Society requested, and received, the coöperation of the Hospital Council of Essex County and the Newark Welfare Federation in making plans for services that would supplement the work of the Bureau. It was found that a great many of the patients who had been referred to this organization were able to pay only part of the minimum cost of the health care they required; but for lack of any other agency to handle these part-pay cases the Bureau was forced to take them. It has been a difficult problem, but great progress has been made and some solution seems in sight.

Plans have been practically completed for the formation of a *collection agency* to handle old accounts exclusively. This agency will be controlled by the Hospital Council and the Medical and Dental Societies. Its rates will be comparable to those charged by commercial agencies, and it will be able to do for the doctors what the Medical-Dental Bureau could never be expected to do for 10 per cent,—collect old bills.

All in all, the Bureau's first year has been most interesting and informative. The operating deficit of $2,800 is well within the amount that any business of this magnitude might be expected to lose in its first year. The amount of business written has been far in excess of expectations, and the $61,000 disbursed to the professional members is an equally pleasant surprise.

Thanks to the assessment levied by the County Medical Society, the Bureau faces 1937 with a balance to its credit. This balance will provide the necessary reserve for Bureau operations, enable a substantial advance to be made to the new professional collection agency for initial capital, and may permit the opening of a branch office of the Bureau within a short time.

Will the Bureau be a success in Essex County? The board has no doubt of it. Patients think it is a fine thing. Professional members have benefited in increased practice and in financial returns.

Should other counties inaugurate similar enterprises? Bear in mind that conditions in Essex County were perhaps the most favorable in the State, with big centers of population to draw upon, nineteen general hospitals, 1,400 members of the organized medical and dental professions; and still the Essex Bureau is having a hard fight.

One thing is certain. No matter how persuasively it may be presented, a Medical-Dental Service Bureau is not the single answer to all the economic ills that beset the practice of medicine. There are specific needs which it can meet. Its possibilities of development are great. It is not, however, an organization that can be created by wishful thinking to do some vague job of economic rehabilitation.

Edwin Parker, *Director.*

POST-GRADUATE INSTITUTE OF THE PHILADELPHIA COUNTY MEDICAL SOCIETY

The following announcement has been sent to the Secretaries of County Medical Societies in New Jersey:

Dear Mr. Secretary:

It would be very much appreciated if, in your County Journal, you would extend to your members a cordial invitation to attend the Second Annual Session of the Post-Graduate Institute of The Philadelphia County Medical Society, in Philadelphia April 12th to 16th, 1937.

We are referring inquiries to you and therefore advise you as follows:

1. Registrants shall be members of a county medical society and must present credentials.
2. Subject, "Diseases of the Chest and Upper Respiratory Tract", to be discussed by fifty teachers.
3. Date of meeting, April 12th to 16th, 1937.
4. Place of meeting, Bellevue-Stratford Hotel, Philadelphia, Pa.
5. Registration Fee, $5.00.
6. Hotel accommodations at reasonable rates may be obtained by writing to Frederick S. Baldi, M.D., Chairman on Hotels, S. E. Corner 21st and Spruce Streets, Philadelphia, Pennsylvania.
7. A scientific exhibit as well as a technical exhibit will be displayed.

Members of all County Medical Societies are cordially invited to register as Annual Members of the Institute, and to attend its scientific sessions. A Philadelphia welcome awaits them.

Further information will be furnished by the Secretary of your Society, or upon application to the Executive Office of The Philadelphia County Medical Society, 21st and Spruce Streets, Philadelphia, Pennsylvania.

FRANKLIN M. CRISPIN,
Executive Secretary.

COURSE IN SYPHILIS

The following announcement of Dr. Mahlon Ashford, Executive Secretary, New York Academy of Medicine, will be of interest to physicians of New Jersey:

At the request of the Commissioner of Health of New York City, The New York Academy of Medicine is sponsoring a course for the physicians of New York City and vicinity in the modern methods of diagnosis and treatment of syphilis.

As you know, this subject is being given special consideration at this time by the Federal Government as well as by New York State and City. In view of the fact that this is a matter of public welfare, the Academy feels justified in requesting you to give this program publicity in your Journal.

Very truly yours,

MAHLON ASHFORD, M.D., *Executive Secretary,*
New York Academy of Medicine.

The program of the course will consist of lectures and demonstrations as follows:

Weekly lectures at the Academy, Wednesday afternoons at 4:30 o'clock:

1. History and Etiology of Syphilis, Howard Fox—February 3.
2. Common Types of Primary and Secondary Syphilis, Louis Chargin—February 10.
3. Unusual Types of Primary and Secondary Syphilis, W. Bayard Long—February 17.
4. Prenatal and Congenital Syphilis, Isadore Rosen—February 24.
5. Significance of Serologic Tests in Syphilis, A. Benson Cannon—March 3.
6. Epidemiology of Syphilis, C. Walter Clarke—March 10.
7. Treatment of Syphilis, Leo Spiegel—March 17.

Practical demonstrations of patients, methods of diagnosis and treatment will be given in the following clinics, February 8 to March 27, 1937:

Borough of Manhattan—
- Bellevue Hospital, Howard Fox, Monday and Thursday, 2-3.
- Health Department Clinic, Louis Chargin, Tuesday and Thursday, 9-10:30.
- Harlem Hospital, Samuel Irgang, Friday, 3-4.
- Lenox Hill Hospital, Leo Spiegel, Monday and Friday a. m.
- Mt. Sinai Hospital, Isadore Rosen, Tuesday and Saturday 2-3:30.
- St. Luke's Hospital, W. Bayard Long, Monday and Thursday, 1:30-3.
- Vanderbilt Clinic, J. Gardner Hopkins, Monday, 3-4, and Thursday, 4-5, beginning March 1st.
- Skin and Cancer Unit, Post-Graduate Hospital, George Miller MacKee, Monday and Saturday, 2-4.

Borough of Brooklyn—
- Health Department Clinic, George F. Hogan, Tuesday and Friday, 9-12.
- Long Island College Hospital, Moses Silverman, Wednesday and Friday, 9-12.
- Kings County Hospital, Alfred Potter, Wednesday and Saturday, 9-12.

Borough of Queens—
- Queens General Hospital, Rudolph Boenke, Tuesday and Thursday, 3-4.

Borough of Bronx—
- Morrisania Hospital, Samuel Feldman, Tuesday and Friday, 9-11.

Attendance is open to members of the medical profession.

MAHLON ASHFORD, *Medical Secretary,*
New York Academy of Medicine.
January 19, 1937.

PARTICIPATION IN THE PUBLIC HEALTH PROGRAM

The following letter is being sent to the Secretary of each County Medical Society with the request that he read it at the next meeting:

The distribution of public funds for public health services under the Federal Security Act is intended to promote the practice of preventive medicine by general practitioners; and the success of the plan depends largely upon the response of the physicians. The agreements of the representatives of The Medical Society of New Jersey with the Social Security managers assumed that the practitioners of medicine would do their part well, and there is every reason to believe that they will do so. However, it must be remembered that the Federal authorities are keeping close watch over the Federal funds, and that any widespread lack of responsiveness on the part of the medical profession will be used as an argument for the assumption of public health practice by the national government; and a resulting restriction of the practice of local doctors.

The Social Securities Act has placed mountainous and enormous burdens upon the State Society, the Public Health Committee, and its seven Advisory Committees and their duplicates in the twenty-one County Societies. The expenditure of nearly $300,000 annually by the State Department of Health along these various lines, in a wise and constructive manner, would ordinarily take ten years to set up. It has had to be devised within a comparatively short period of time, and could not be allowed by the medical profession to fall into political hands. It is now being set up by the joint continual conference between the officials of The Medical Society of New Jersey and the State Department of Health to improve the public health of the communities of the State. The interest and loyal participation of every member of the State Society is needed to keep this movement guided along proper channels; and more particularly to retain for the County and State Medical Society the control of the medical services to be rendered, whether by group methods, or by subsidy of the doctor's individual office.

We ask that any member who does not understand our efforts along any of the State and County Medical Public Health plans in any of these fields of Preventive Medicine now to be read, shall ask the Chairman of the Public Health Committee of his County Medical Society for such information; or to secure it for the member from the State Office of The Medical Society of New Jersey, if he cannot find it in the issues of the State Medical Journal.

The fields of practice in which the physicians of New Jersey are expected to coöperate with the State and Federal authorities are as follows:

1. Public Health Hour
2. Maternal Health
   a. Pre-natal
   b. Improved obstetrics
   c. Post-natal
3. Regular Infant Supervision
4. Regular Health Supervision of the Pre-school Child
5. Regular Health Supervision of the School-age Child
6. Regular Adult Health Supervision (including periodic, or birthday examination)
7. Cancer control
8. Tuberculosis Control
9. Venereal Disease Control
10. Mental Hygiene
11. Prevention and Control of Blindness and Deafness, etc.
12. Other Special Minor Fields in Preventive Medicine and Health Education

The physicians of New Jersey are already engaged in these divisions of practice, and their coöperation with the State and Federal authorities will promote their own interests as well as the welfare of the people. The active participation of physicians in these twelve activities will enable the medical profession to attain the objective:

"Every Physician's Office a Health Center"

Stanley Nichols, M.D., *Chairman*
The Public Health Committee of
The Medical Society of New Jersey

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS SINCE JULY 1, 1936

DIPHTHERIA TOXOID

County	To Dec. 31	Month of Jan.	Total to Jan. 31	Average per Month
Atlantic	183	59	242	34.5
Bergen	895	92	987	141.
Burlington	156	33	189	27.
Camden	440	22	462	66.
Cape May	41	9	50	7.1
Cumberland	235	5	240	34.2
Essex	7679	635	8314	1187.7
Gloucester	139	15	154	22.
Hudson	104	10	114	16.4
Hunterdon	23	0	23	3.2
Mercer	32	1	33	4.7
Middlesex	907	99	1006	143.7
Monmouth	436	134	570	81.4
Morris	137	78	215	30.7
Ocean	127	51	178	25.4
Passaic	1300	1383	2683	383.4
Salem	43	8	51	7.2
Somerset	1531	4	1535	219.2
Sussex	65	0	65	9.2
Union	763	37	800	114.2
Warren	349	4	353	50.4
Totals	15585	2679	18264	2609.1

SMALLPOX VACCINE

County	To Dec. 31	Month of Jan.	Total to Jan. 31	Average per Month
Atlantic	421	3	424	60.5
Bergen	819	84	903	129.
Burlington	217	0	217	31.
Camden	456	3	459	65.5
Cape May	57	0	57	8.1
Cumberland	281	40	321	45.8
Essex	3277	240	3517	502.4
Gloucester	300	7	307	43.8
Hudson	66	1	67	9.5
Hunterdon	21	0	21	3.
Mercer	72	0	72	10.2
Middlesex	538	65	603	86.1
Monmouth	1363	152	1515	216.4
Morris	704	53	757	108.1
Ocean	104	0	104	14.8
Passaic	1740	102	1842	263.1
Salem	25	7	32	4.5
Somerset	39	0	39	7.5
Sussex	122	0	122	17.4
Union	939	40	979	139.8
Warren	524	7	531	75.8
Totals	12085	804	12889	1841.2

BOOK REVIEWS

EXOPHTHALMIC GOITER AND ITS MEDICAL TREATMENT, by Israel Bram, M.D. C. V. Mosby Co., St. Louis, Mo., 1936. 456 pages, illustrated.

This is the second edition of Dr. Bram's work originally published in 1920, but, as he says in the foreword, it is in reality practically a new book because of the tremendous strides that have been made in thyroid disease in the past fifteen years. It covers the experience of a man who has devoted much of the last twenty-five years to the experimental and clinical study of exophthalmic goiter. It is the author's personal experience with over 5000 cases.

Although the profession as a whole may not agree with the medical treatment of thyroid disease, it should individually commend and study the methods which will produce a mortality rate of 0.3 per cent and 90 per cent permanent cures in such a large series. In the reports of surgically treated cases the author is usually well satisfied with a mortality of 0.5 per cent with no estimation of permanent cures. Dr. Bram does advise surgery in about two per cent of cases—those not improved by medical treatment after six months, those with obstructing symptoms, those with an iodine fast status, and those with complicating uncontrolled diabetes.

This book is worthy of study if for no other reason than it presents the treatment of the "patient as a whole" from the psychological as well as the general medical angle. One is apt to think of this complex disease as limited to the gland itself. He draws especial attention to the fact that this syndrome is not a local disease and that it is often interrelated with other glandular dysfunction.

The profession has seen the treatment of peptic ulcer swing from surgical to medical treatment and then to a combination of them both as neither was alone sufficient. That surgical partial ablation of the gland is not curative in all cases no one will admit more freely than the surgeon of wide experience. Dr. Bram seems to have succeeded well in treating this type of thyroid disease, but at present his conclusions, as to medical treatment in the majority of cases, are at variance with other physicians of equally wide experience.

STUART ZEH HAWKES, M.D.

PARENTERAL THERAPY, by Walter Forest Dutton, M.D., and George Burt Lake, M.D. Published by Charles C. Thomas. Copyright 1936.

This book considers all forms of therapeutic administration of drugs with the exception of those given orally. The various technical procedures are given in detail in a manner never before attempted. Hundreds of procedures, such as intradermal, intramuscular and intraspinal injections, cisternal puncture, spinal anesthesia, alcohol injection for nerve block, injection treatment for varicose veins, hernia, etc., are given in full detail. Inhalation therapy and Ionic medication are also considered. This information, collected from hundreds of sources, has not been available within the covers of one volume. The second and third parts are devoted to a therapeutic index and pharmacologic notes which include many recent drugs, their action, uses and sources of supply. There is an index of subjects, an index of names and a few blank pages for notes.

It is easy for the general practitioner or specialist to read and is intended for the physician, dentist, nurse, veterinarian or pharmacist who is called upon to meet emergencies. It is a grand start in bringing what we know in the way of technical procedures up to date in a ready reference work.

EDGAR P. CARDWELL, M.D.

OBITUARIES

Special efforts have been made that the *Journal* should recognize the good work done by State Society members whose deeds live after them. The Reporters of the County Societies have been efficient in sending memorials, but the Journal also asks the assistance of the members, especially for data regarding those who had retired from active practice. While the obituary of a physician will record his professional career, equally important is the human side of his life—his church and lodge, his avocations, his civic services, his kindly peculiarities, and his outstanding contributions to the life of his home town.

DR. FRANK C. BUNN

Dr. Frank Caulkins Bunn, senior surgeon of the Homeopathic Hospital of Essex County, East Orange, died at his home in Orange, on January 11, 1937, aged sixty-eight years. Surviving are his wife, Mrs. Annie Louisa Pray Bunn; a son, Frank C. Bunn, Jr.; two daughters, Mrs. Guy F. Hunter and Mrs. John Curtis, Jr.; a stepbrother, Richard K. Mosley; and a stepsister, Miss Eleanor Mosley.

Dr. Bunn practiced medicine in New Jersey for forty-seven years, and was a noted surgeon. He helped to found the Homeopathic Hospital, and was instrumental in its transfer from Newark to East Orange in 1926. He was also consulting surgeon of St. Mary's Hospital, at Passiac; Fitkin Memorial Hospital, at Neptune; the Essex County Isolation Hospital, at Soho; the Montclair Community Hospital, and the Presbyterian Hospital, at Newark.

DR. CHARLES V. NIEMEYER

Dr. Charles V. Niemeyer, of 4610 Boulevard, Jersey City, died on January 11, 1937, from myocarditis. He was born in New York City in 1889, and graduated in medicine from the University of Vermont. He began the practice of medicine in 1906, specializing in pediatrics. In 1920 he organized a series of public clinics in Monmouth County. He was a member of the Hudson County Medical Society, The Medical Society of New Jersey, a Fellow of the American Medical Association, and a member of the American College of Physicians.

DR. JOHN F. HAGERTY

Dr. John F. Hagerty, Past-President of The Medical Society of New Jersey, died in his home at 590 Clinton Avenue, Newark, on February 1st, of pneumonia, after an illness of one week.

Dr. Hagerty was a native of New Brunswick, where he was born on May 9, 1869. He graduated from Rutgers College, and received his Medical degree from New York University in 1892. He served as interne in Bellevue Hospital and practiced medicine in Newark during the rest of his life, specializing in surgery. At the time of his death he was attending surgeon and medical director of St. Michael's Hospital in Newark, attending surgeon at the Hospital and Home for Crippled Children of Newark, consulting surgeon at St. Peter's General Hospital, New Brunswick; attending surgeon at St. Mary's Hospital in Orange, and consulting surgeon at the Presbyterian Hospital in Newark, and at St. Vincent's Nursery and Babies' Hospital in Montclair.

Dr. Hagerty was an active leader in medical societies, both local and State, as well as national. He passed through all grades of service in the Essex County Medical Society and The Medical Society of New Jersey, becoming President of each, and at the time of his death he was the Senior Delegate from New Jersey in the American Medical Association.

(A fuller biography and a portrait will appear in the March Journal.)

LIST OF PHYSICIANS DYING IN NEW JERSEY IN DECEMBER, 1936

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Charles F. Adams	77	Dec. 14	Trenton	Same	Cerebral apoplexy.
Jonas A. Henry	33	Dec. 3	Atlantic City Hosp., Atlantic City	1204 Columbia, Pleasantville	Acute bronchitis. Chronic nephritis.
William W. Kain	80	Dec. 14	Middle Twp., Cape May Co. (Rio Grande)	Same	Lobar pneumonia.
Mathias J. Schmitz	72	Dec. 2	Denville	Same	Coronary thrombosis. Arterio sclerosis. Myocarditis.
Arthur J. Schneidenback	60	Dec. 12	Hackensack Hospital,	Hackensack	Acute ileus.
Henry V. Stout	81	Dec. 4	Livingston	Same	Cerebral apoplexy.
Nellie Tilton	55	Dec. 20	Medical Center, Jersey City	Same	Pulmonary edema. Congestive heart.
Henry M. Woolman	69	Dec. 5	Ocean Tp.(Wanamassa)	Same	Cerebral apoplexy.

CONTACTS AND COMMENTS, No. 4

THE ANNUAL MEETING

The officers and committees of The Medical Society of New Jersey are putting forth every effort to make the next Annual Meeting the most successful that has ever been held. The central feature will be the scientific sessions when the members may hear outstanding speakers on up-to-date features of the practice of medicine, equal in value to those at the American Medical Association and other national organizations.

The meeting of the House of Delegates will reveal the great progress which has been made in securing the active participation of the individual members in exemplifying the high principles of the medical profession in their private practice.

The three exhibits will provide unequalled opportunities for the members to see the tangible progress which has been achieved in the lines of scientific research, and new apparatus and preparations, and the display of the results of worth-while avocations of the members.

All these features will be combined with social opportunities for the doctors to meet their fellow members of the great medical fraternity of New Jersey. The inspiration engendered by these social contacts will be the most valuable and enduring of all the impressions of the Annual Meeting.

Dr. Elmer P. Weigel, President of the Union County Medical Society, has sent the following personal appeal to each member of the Union County Medical Society:

The Union County Medical Society last year authorized the formation of the Medical-Dental Service Bureau. We are still convinced that the idea behind the bureau is sound. It can render a material service to both the doctor and his patient and at the same time serve as the answer of organized medicine to many of the arguments for Socialized Medicine.

The chief work of the Bureau has been to help patients of lesser incomes to finance contemplated medical care. The scope of the work of the Bureau has now been broadened to include the collection of unpaid bills. This work will be done by the regular staff of the Bureau with the aid of a competent attorney and when necessary by legal action. However, no suits will be instituted in any case without the authorization of the physician in such case, and in all events, the collections will be made through the Bureau. The charge for this collection service will be 20 per cent of the amount collected.

The trustees feel that if each member will turn over his unpaid bills to the Bureau for collection, the revenue derived therefrom will be sufficient to support the Bureau, and at the same time help all the members to realize materially on old outstanding accounts.

As President of the Union County Medical Society, I am appealing to you to use the facilities of the Bureau for new cases; but above all by sending your unpaid bills in *at this time* for collection.

Sincerely,

E. P. WEIGEL, *President.*

On page 125 there appears a letter from Dr. Stanley Nichols, Chairman of the Committee on Public Health, to be read before each county society, appealing to the members to coöperate in a concerted plan of action to give better service than ever before in seven chosen lines of practice. Read the editorial comment on page 73 of this Journal.

Equally important to efficient medical service is the demand for that service by the people. Read the editorial on "Production and Salesmanship" on page 75.

The January issue of this Journal was a picture book, because authors and contributors supplied an unusual number of illustrations. It is the policy of the Publication Committee to use photographs and diagrams, believing with the Chinese that "A picture is worth a thousand words".

If your county society has an outing, send snapshots of the dignified elders pitching horseshoes, or the recent graduate reciting poetry. These pictures will acquire a high historical value within a decade. The oldest group picture which is available is that of the members attending the Annual Meeting of the State Society in 1893. It shows ninety physicians of whom only forty can be identified.

Do you think it worth while to use more photographs in The Journal?

The February Bulletin of the Burlington County Medical Society contains a record of the appointment of a committee to establish a "Physicians' Credit Bureau" for rating debtors financially, and for collecting over-due debts. It is proposed that a manager be employed to carry on the work. The item closes with an appeal to every member to support the Bureau so that it may have enough business to succeed.

The Medical Society of New Jersey took an active part in the Winter Conference of the New Jersey Hospital Association, which was held on the evening of January 27 in the building of the Academy of Medicine, Newark. The general subject of discussion was "Hospital Relations", especially those of the staff of physicians with the trustees and board of managers. Dr. S. T. Snedecor, President of The Medical Society of New Jersey, presided, and the program consisted principally of a presentation of the point of view of the physicians. Their papers were clear and concise; and it is planned that the subject at the next conference will be a reply by the boards of managers.

Look for a report of the meeting and abstracts of the papers in the next issue of The Journal.

VERSES BY PHYSICIANS

Physicians of New Jersey are not much given to poetic expression, but we have received a book of verses from Dr. H. Ameroy Hartwell, of Weehawken, who also has the ability to set his words to music. His range of thought is wide, but here and there he touches the professional experience of the physician, as in the following verse:

"Stand by! physicians of weak human's blight
Who touch the throbbing pains with hands that heal;
Steer free from all the treacherous lanes not planned
By statlier communistic shackled might.
Today, united still, we hold the wheel
Which guides the rudder safely to the land."

Dr. E. S. Corson, reporter for the Cumberland County Medical Society, also wields a ready pen in rhyme and meter, as in the following quotation:

"Just a minute of the Old Year
Perhaps made you rich or poor;
Just a minute of the New Year
Changed from last mistakes may cure."

LIFE EXTENSION INSTITUTE, INC.

The Life Extension Institute, Inc., of New York City was the defendant in an action brought by the Attorney General of the State of New York in the Supreme Court to dissolve the Institute for the reason that it had engaged in the practice of medicine, which a corporation could not legally do.

The business of the Institute consisted fundamentally in making physical and laboratory examination of patients, supplying them with diagnoses, and then referring them to their family doctors for treatment. But a large proportion of its business consisted in examining policyholders at the expense of life insurance companies, who profited by the treatments which the patients voluntarily sought.

The examinations and diagnoses were made by physicians who were hired on salary by the Institute; but the fees for the examinations were paid by the patients to the Institute. The Institute maintained an extensive suite of offices and maintained x-ray and chemical laboratories for making physiological and pathological tests.

The Institute, in fact, practiced all forms of medicine except giving drugs, performing operations, or having the patients return for routine advice.

The trial of the case was conducted in a friendly manner, and much evidence was taken to show in a judicial manner that the defendant had actually engaged in the practice of medicine. The case did not go to judgment, but was settled by the voluntary action of the responsible officers of the Institute that it would cease from performing any of the acts which constitute the practice of medicine.

An agreement was also reached regarding what the acts the Institute can do and continue in business. The agreement was that the Institute may enter into contracts with physicians to make diagnoses and suggest treatments, provided the Institute had nothing to do with the financial relations between the patients and the doctors. It is presumed that the Institute will continue to do business by methods which a patient could not distinguish from the former way.

Whatever may be the opinion of physicians regarding the Institute, the majority agree that the Institute has done valuable service by demonstrating practical methods of making physical examinations of adult persons; and also by popularizing the examinations through a widespread system of advertisements in the daily press. Physicians will be interested in seeing what kind of lawful system the Institute will develop in the future.

The following anatomical gem is culled from the weekly "Buzzer" of the Trenton Y. M. C. A.

BONES

The bones in the body are two hundred and more,
But for sorting out people we need only four:

Wishbones

They hope for, they long for, they wish for, and sigh;
They want things to come, but aren't willing to try.

Funnybones

They laugh, grin, and giggle, and twinkle the eye.
If work is a joke, sure, they'll give it a try.

Jawbones

They scold, jaw, and sputter, they froth, rave, and cry;
They're endless on talk but they're short on try.

Backbones

They strike from the shoulder, they never say die.
They're winners in Life, for they know how to try.

That the hour of meeting has an influence on attendance at a medical meeting is shown by the following note in the January issue of the Warren County Bulletin:

The last meeting, which was held in Washington, was very well attended. There are reasons for the increase in atendance. First, it is thought that a change in time to the afternoon was the greatest factor. Secondly perhaps was the location. Surely there were more men from Hackettstown and that was very gratifying. Lastly and in no way the least were the speakers.

Notice that this meeting is being held in the afternoon at 3:30 Tuesday, January 19, 1937, because it is felt that more men will attend at that hour.

The February Bulletin of the Camden County Medical Society contains the following note:

A bill for sterilization of mental defectives was introduced at the last session of the Legislature by the N. J. League of Women Voters. It was not voted upon.

The Medical Profession will be compelled to take a stand on this important question from the point of economics. Twenty-eight states have laws which have controlled the continued propagation of these defectives. Our efforts might well be directed along these lines rather than birth control in the normal individual.

The physicians of Middlesex County were the leaders in establishing The Medical Society of New Jersey 171 years ago; and their originality and leadership is still evident in the following quotations from the January Bulletin of the County Society:

If I were to assume a slogan for this year it would be, "Service to the Physician". Much of my effort will be directed toward organization of the County Society in an effort to make it act as a single body with such efficiency and direction that its power will be felt throughout the State. This goal can be very easily accomplished by the efficient coöperation and coördination of the various committees when their efforts are properly placed and properly timed. The work of all the committees will be assisted by means of the "Field Secretry", in order to relieve the burden of the busy physician. If every member of the County Society on the various committees gives a small amount of assistance on the few occasions that he may be called upon, the effort will reach maximum efficiency.—*From President Rowland.*

BULLETIN POLICY

The *Bulletin* now begins its second volume. It is your property and it should be used as a medium for the expression of your opinion. The *Bulletin* also serves as a liaison between the *President* and his *committees* and the *society* members. Business is transacted at the regular meetings and we hope to keep you informed as to what has happened and what matters will be brought up at the coming meeting. We ask the coöperation of every member in order that our usefulness be increased. In so far as limited space permits, your requests and opinions will receive attention. We also solicit personal items concerning members and of general interest to the *society.*

Committee appointments for the year have been made. Practically everyone is placed on at least one. This is an opportunity for service to the *Society.* No member need feel that he is just a spectator at meetings. The younger men are strategically placed and this should be an incentive for accomplishment. It should also help increase attendance at meetings. Dr. Mann in his address, wisely stressed the dual function of the *Society;* namely, scientific and economic. The importance of the economic activities is daily becoming more apparent. No one can afford to miss a meeting. Vital decisions concerning policy are made. The day of the rugged individualist is passed. We must act in concert.

Attention—The County Society still retains the services of Miss Kidd, as secretary. She has desk room in the Physicians and Surgeons Exchange, 105 Carroll Place, New Brunswick. The phone numbers is N. B. 7777. Please make a memorandum of this.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

February				March			
2	Camden	11	Essex	2	Camden	12	Atlantic
2	Hudson	11	Passaic	2	Hudson	17	Middlesex
9	Bergen	11	Somerset	9	Bergen	18	Gloucester
9	Cumberland	12	Atlantic	10	Mercer	18	Morris
10	Mercer	12	Salem	10	Ocean	24	Monmouth
10	Ocean	17	Middlesex	11	Burlington		Sussex (At call
10	Union	18	Gloucester	11	Essex		of President)
11	Burlington	24	Monmouth	11	Passaic		

ATLANTIC COUNTY

E. H. Nickman, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held at the Ambassador Hotel on January 8th, 1937, at 8:30 p.m., Dr. J. S. Irvin presiding. There were fifty members and guests present.

COUNCILOR'S VISIT

Dr. Chester Ulmer, Councilor for this district, and Dr. E. E. Downs were present. Dr. Ulmer congratulated the society on the Supplement being sent out with the monthly bulletin and urged the delegates from this society to attend the meetings of the other counties in this district in order not only to promote a better spirit of fellowship but to increase solidarity of the profession.

LECTURES

Dr. S. G. Stewart, Chairman of the Post-Graduate Education Committee, reported that a course of six lectures could be arranged for this year. The nature of the lectures and the time will be announced later.

WOMAN'S AUXILIARY

Dr. W. A. Blampin, Chairman of the Woman's Auxiliary Committee, reported that the Auxiliary was very busy and had many projects under way.

BROADCASTS

Dr. M. B. Holoman, Chairman of the Broadcasting Committee, reported that the same hour would be allotted to the Society over WPG and that programs would be arranged in the near future.

NEW MEMBERS

Dr. D. B. Allman, Chairman of the Board of Censors, stated that Drs. Forsythe, Chalfant and Diskan were recommended for membership, and they were unanimously elected.

RAGWEED EXTERMINATION

Dr. Irvin stated that during his administration he would like to see something done by the Society toward the extermination of ragweed from Absecon Island so that Atlantic City could be advertised to hay fever sufferers. Following discussion by Drs. Hyman, Salasin and Barbash, a motion was passed that the President appoint a committee to see the proper authorities to start work on this project.

PUBLIC HEALTH FORUM

Dr. E. L. Shore announced that a Public Health Forum would be held in the High School Auditorium on January 19th. The people of Absecon Island will be circularized by sending pamphlets home by every school child. Dr. J. B. Morrison, Secretary of the State Society, will be the speaker and his subject will be Socialized Medicine. The meeting will be in the nature of a forum with questions asked and answered. Dr. Shore urged the members to attend (p. 114).

SCIENTIFIC

The Scientific Program of the evening was presented by Dr. S. A. Lowenberg, Associate Professor of Medicine, Jefferson Medical College, the title of his address being "The Diagnosis and Treatment of the More Common Forms of Cardiac Infections". The paper was greatly enjoyed by those present and was briefly discussed by Drs. Scanlan, Barbash, and Stewart.

BERGEN COUNTY

L. W. Black, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held at the Hackensack Hospital, on Tuesday, January 12th, 1937.

NEW MEMBERS

The following were elected to membership:

To Junior:
Dr. Lewis A. Klein, Teaneck
From Junior to Regular:
Dr. E. J. Kakascik, Garfield
To Regular:
Dr. Joseph T. McGuire, Lodi
Dr. Ralph Brennan, Radburn
Dr. Eufelia Pingatore, Hackensack
To Associate:
Dr. Thomas Lowry, Ridgewood

The following applications for membership were read:

To Junior:
Dr. R. Dahlquist, Hackensack
Dr. Edmund E. Jacobitti, Maywood
Dr. James M. Jones, Teaneck
Dr. Sarah Gordon, Teaneck
From Junior to Regular:
Dr. Joseph B. Basralian, Hasbrouck Heights
Dr. Vincent P. Candio, Lyndhurst
Dr. Kalman Chase, Hohokus
Dr. Samuel Loman, Cresskill
To Associate:
Dr. Arthur F. Coca, Oradell

COMMUNICATIONS

1. A notice from the Philadelphia County Medical Society inviting our physicians to attend the Second Annual Session of the Post-Graduate Institute, from April 12th to 16th.

2. A notice from the Bergen County Pharmaceutical Association that it had passed a resolution urging its members to discontinue printing prescription blanks for doctors with the name of the pharmacist on the blank. The resolution was ordered to be printed in the next Bulletin.

VENEREAL DISEASE COMMITTEE

Our President announced the following members on the Venereal Disease Committee as a sub-committee of the Public Health Committee:

Dr. S. B. Reich	Dr. W. L. Jordan
Dr. S. T. Dayton	Dr. H. Oren
Dr. A. Greenfield	Dr. E. N. Huff

Dr. A. T. Brennan

MEDICAL-DENTAL SERVICE BUREAU

Dr. Irwin introduced Dr. Sigurd Johnsen, representing the Board of Directors of the Passaic Medical-Dental Service Bureau. Dr. Johnsen explained the need of this service and invited us to participate.

Mr. James Smiley Kinne, Executive Director of the Bureau, explained the services of the Bureau in detail.

SCIENTIFIC

Dr. Theodore Neustaedter, Chief of Endocrine Clinic of Post-Graduate Hospital, gave a very complete description of the endocrine secretions and explained their actions as far as is known today. He listed the following preparations as being of value:

Estrogenic Substances
Amniotin
Theelin
Progynon (amp)
Progynon D H (tab.)
Theelestrin
Corpus luteum products
Progestin—Upjohn
Proluton—Schering
Pituitary Stimulators
Antuitrin S
Follutin
A P L Collip

Drs. H. Trossbach and L. Burnham took part in the discussion.

BURLINGTON COUNTY

Parry M. Scott, M.D., Reporter

The December meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club, Moorestown, N. J., Thursday, December 10th, 1936. The meeting was called to order by President Small. Dr. Joseph Stokes reported for the committee selected to prepare a suitable testimonial to Dr. Tracy for his thirty-two years of service as Secretary to the Society. The committee had selected a desk chair as a gift and had prepared a resolution of appreciation for Dr. Tracy to be framed. The society accepted the committee's recommendation.

SCIENTIFIC

Dr. Shipps introduced the speaker of the evening, Hobert A. Reimnan, professor of Jefferson Medical College, who spoke on "Recent Advances in Infectious Diseases". Some of the salient points of the talk are enumerated below.

Pneumonia: This disease with 500,000 cases per year is worse than any infectious disease except tuberculosis. It is now realized there are numerous forms of this disease, and that there are thirty-two different types of pneumococcus. Immune serum has been prepared for only Types 1, 2, 5, 7, and 8.

Type 1 has more complications than any other type, is found mostly in young children, is due to contact, and temperature falls by clysis.

Type 2 is also due to contact. Endocarditis is the most common complication.

Type 3. This disease is secondary to other diseases. Is found in old people.

Type 5 is similar to type 1; and type 8 is similar to type 2.

Type 14 is invasive type. Is found in children and infants. Immune serum is of value in cases of suitable type but not of any value after four or five days. Recent work has greatly simplified and concentrated the serum.

Streptococcus Pneumonia: Streptococcus pneumonia is similar to influenzal pneumonia. Antistreptococcus serum is of value in a number of cases. Artificial pneumothorax is not of any value in the treatment of any form pneumonia.

Influenza: In this infectious disease most interesting work has been done in the immunological phase. Research work done on hog influenza shows identical immunological traits with human virus. There is a question as to whether the organism which causes pandemic influenza is the same as that of epidemic influenza. Mice can be immunized by the injection of antibodies; and antibodies have been developed in people who have had pandemic attacks. It has been found that ultra-violet ray kills ferret virus in the air.

Acute Rheumatic Fever: Recent study of rheumatic fever shows that streptococcus hemolyticus causes a relapse; and while it is an exciting factor, it has not been proven to be definite cause. One point of distinction found in a patient recovering from rheumatic fever not present in rheumatoid arthritis is the presence of anti-fibrinolysin.

Undulant Fever is apparently an old disease, but the first case was reported in 1924. Last year there were 2000 cases reported. Evidence shows certain characteristics of undulant fever, particularly the

presence of neurotic symptoms. That some people have a high immunity to undulant fever is beyond question, as is shown in an institution of 300 people who drank contaminated milk. Five per cent contracted the disease; one per cent died; and 35 per cent had a positive skin test.

Tetanus: Experimental work has developed a new pathogenesis of the disease. Definite evidence shows that the disease is carried in the blood stream. The question arises as to whether the antitoxic serum is of any value in the treatment of the disease; or whether the use of new sedatives such as avertin are the chief factors in the cure.

Dr. W. G. Herrman, Vice-President of The Medical Society of New Jersey, gave lantern slides illustrating the aims of the society of the coming year, and the desire for closer coöperation between individual units of the society.

CREDIT BUREAU

Dr. Scott referred to previous suggestions as to the formation of a *Credit Bureau* controlled by the county society for the preparation of a list of bad debtors as a means of collecting overdue bills. Dr. Small appointed Dr. Scott chairman of the committee to prepare some plan to present to the society, and to select two other members to act with him on this matter.

Dr. LeFavor issued an invitation from the Ladies' Auxiliary for a joint meeting in the Spring.

Adjournment was followed by refreshments.

CAPE MAY COUNTY

Warren D. Robbins, M.D., Reporter

A special meeting of the *Cape May County Medical Society* was held on Tuesday, January 19th, 1937, at the Bellvue Hotel, Cape May Court House, N. J., with the President, Dr. John B. Townsend, presiding, and the following members present: Drs. Bernheisel, Corson, Crowe, Cryder, Dandois, Friedland, Gidding, Haines, Mace, Moon, Pettit, Pressman, Robbins, Tomlin, Townsend, Ziegler. Guests included Dr. H. H. Wilson, of Bridgeton; Dr. H. J. Schroeder, of Trenton; Dr. August Jonas, of Wildwood; and Dr. Kasab, of Chester.

The reports of the various county committees were received.

MEMORIAL

Resolutions were adopted expressing the deep sorrow of the society at the passing of Dr. Julius Way and Col. C. M. Gandy.

MEMBERSHIP

The application of Dr. August Jonas, of Wildwood, was read and referred to the Board of Censors, who approved the application.

The request of Dr. Earl C. Hallinger for transfer to the Gloucester County Medical Society was approved.

COMPENSATION COMMITTEE

In reply to a letter from the State Compensation Committee, the recommendations of the society were to be made by the Chairman of the Legislation Committee, Dr. Allan Corson.

SCIENTIFIC

Dr. H. J. Schroeder, of the State Tuberculosis Department, gave an interesting talk on Pulmonary Tuberculosis, in which he stressed the importance of early diagnosis and frequent sputum examinations.

At the conclusion of the business session, a buffet supper was served.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held at 9 p.m. on Thursday, January 14, 1937, at the Academy of Medicine, Newark, with the President, Dr. Edgar A. Ill, presiding.

CENTRAL ADMITTING BUREAU

Dr. Satchwell read the report of the Medical-Dental Service Bureau. This showed some very interesting figures. Dr. Satchwell paid tribute to Mr. Parker, Executive Director of the Medical-Dental Service Bureau for the very fine showing of the first year of operation. (See page 123.)

Regarding the *Central Admitting Bureau,* Dr. Satchwell stated that the Trustees of this Bureau are about ready to submit a report as to costs, etc., to the Welfare Federation, which already approves it in principle. The primary question is, Will it cost more for a Central Admitting Bureau than the present set-up in use in the hospitals at the present time? It is believed that the cost will be less. This Central Admitting Bureau will be entirely independent of the Medical-Dental Service Bureau. It will have its own Board of Trustees, four members from the hospital group, four members from the medical group, representatives from the Welfare Federation, the Hospital Council; Mr. Parker and Mr. Colman of the Hospital Council. The need for this agency is quite apparent.

The *Collection Agency* is about ready to be launched with about $50,000 worth of accounts from the Medical-Dental Bureau for collection. The plan for the agency has been approved by the Council, which recommends approval by the society. President Dr. Edgar A. Ill will then appoint four members to the Board of Trustees. Tentative charges decided upon are 40 per cent for bills under one year; 50 per cent for bills over one year. Court costs will be included in this charge. After the agency has been in operation for three months, the work will be reviewed and the plan remodeled if necessary, reducing the cost to the physician if possible. The fiscal year report of the Medical-Dental Service Bureau showed a surplus in the Treasury which will finance the cost of the medical group's share toward the establishment of this collection agency.

It was regularly moved and seconded that the society approve the plans for the collection agency and ask the President to appoint four members to the Board of Trustees.

REPORT OF THE MEDICAL-DENTAL SERVICE BUREAU

The Medical-Dental Service Bureau closed its first fiscal year on December 31st. Although the annual report has not yet been completed, I can assure you

that it is most satisfactory and shows accomplishments far in excess of our expectations. Dr. Rogers, Treasurer of the Bureau, has asked me to give you the following figures:

Value of business written, December 9, 1935, to December 31, 1936, inclusive:

Medical	$ 68,854.95
Dental	9,868.00
Hospital	64,544.54
Total	$143,367.54

Payments made to professional members for the above period:

Physicians	$27,801.74
Dentists	5,302.65
Hospitals	28,294.57
Total	$61,398.96

Please note that of the $61,398 actually disbursed to the professional members by the Bureau, almost identical amounts went to the physicians, and to the hospitals. No clearer indication of the Bureau's value to the physicians could be given than these figures showing the extent to which the physicians share in all payments made. Of course, if there had been no Bureau the physicians would still have collected *some* money, but I leave the amount of such receipts to your imagination.

The new year is also off to an auspicious start with the number of cases referred thus far in January showing a big increase over last month. There is another matter connected with the Bureau which I am glad to report. Last May this society voted a special assessment of $10 per member to "help establish a Central Admitting Bureau for Hospitals". Detailed plans for this admitting bureau have now been drawn up and undoubtedly will be presented to the committee at its next meeting. Some of the assessment money has been used by the Medical-Dental Service Bureau to accept and handle, at a loss, cases for several hospitals which are not normally within its scope. These cases have been accepted as a demonstration of the need for such an Admitting Bureau as this Society has proposed, and have proved the most concrete illustration obtainable of the necessity for such an organization. These cases have been the kind that could pay no physician's fee and only a part of the minimum hospital rates. Their handling has caused the Bureau far more trouble than the average private case and the income has been distinctly limited. This practical demonstration, you might say "this hospital admitting set-up on a small scale", has cost the Bureau money. Part of the assessment has therefore gone to meet this expense. As a matter of fact, the Medical-Dental Service Bureau will have to continue to carry this load until the hospital admitting set-up is in operation. In addition to this practical demonstration of a hospital admitting set-up, the Trustees of the Bureau have also been driving toward the establishment of a professionally owned and operated *collection agency* for delinquent accounts. A separate report will be given on this agency, but I can state here that all the capital necessary to start this agency, as far as the Medical Society is concerned, is available from funds paid in from the assessment.

Just one more point. If the members of the society continue to pay up this assessment at the same rate at which they have responded during the past two months, we will have sufficient funds to guarantee the opening of a branch office in the Oranges in the immediate future. We have already gone so far as to make a tentative selection of personnel and a bookkeeping set-up. Allow me to summarize the results of the assessment voted last May. Although the response was negligible until a relatively few weeks ago, the money we asked for "to establish a central admitting bureau" has actually:

1. Helped bring the admitting bureau into the form of a definite plan ready for submission.
2. Provided the capital required from the Medical Society to put into immediate operation our own professional collection agency.
3. Given us a good share of the funds we need to bring the services of the Medical-Dental Bureau to more men by the establishment of an Orange branch.

Three things for the price of one is a good buy. We earnestly request the many men who have not yet paid their special assessment to do so immediately so that there may be no hitch in this program.

Harry H. Satchwell, M.D., *Secretary.*

HOSPITAL COMMITTEE

Dr. Pinneo read the report of the *Hospital Committee* for Dr. Sprague, who was absent. This report contained two resolutions to come before the members of the society—the one dealing with the *Protection of Interns in Hospitals* against malpractice suits, recommended to the Council that arrangements be made with the present Insurance Company for inclusion of a state-wide blanket policy protecting internes. This was made a motion, seconded and carried.

Internes' Certification of Deaths. A letter was read by the Chairman from the Secretary of the Maternal Welfare Commission containing the following resolution: *"Resolved,* that letters be sent to the President of the Staff of each hospital in Essex County, stating that this Commission feels no interne should sign any maternal death certificate, including deaths after abortions and ectopic gestations, without the approbation of the attending physician." Discussion of this problem followed and it was agreed that the above resolution be adopted by this committee, but that it read, "No internes shall sign *any* death certificate without the approbation of the attending physician or his assistant." It was regularly moved and seconded that this report of the Hospital Committee and its resolutions be accepted.

BY-LAWS

Some changes in the By-Laws concerning the moral and professional misconduct and the method of discipline were read. These changes have been considered and approved by the Economics Committee and the Council. The adoption of the following was recommended:

"Moral or Professional Misconduct shall include what is commonly known as 'Case Lifting', 'The

Giving of Improper Court Testimony', and 'The Publishing by Any Member of a Newspaper Article Concerning the Ability or Abilities or Professional Acts of Physicians', any of which are contrary to the best interest of both the public and the medical profession and are deemed to be unethical.

" 'Case Lifting' is defined as taking a patient from a physician who is being dismissed for any reason other than the voluntary choice of the patient, excepting, however, the treatment of injured workmen who may be treated by the employer's own physician.

" 'Improper Court Testimony' shall be defined as the giving of testimony, under oath before any judicial authority, which in the opinion of the Council is false, misleading or exaggerates or minimizes the injuries or conditions about which the physician may testify.

" 'The Publishing of Newspaper Articles Concerning the Ability or Professional Acts of Physicians' shall be defined as such article or articles appearing in any publication other than a strictly medical publication, or articles appearing with the knowledge of the physician concerned.

"In addition to the foregoing acts committed by any member, any act that is deemed by the Council to be detrimental to the best interests of the medical profession shall likewise be deemed moral or professional misconduct.

"Section 3.—Upon a member being found guilty of any act mentioned in Section 2, such member may be disciplined, suspended or expelled from this society by a three-fourths vote at any meeting of the Council at which a quorum is present.

"Section 4.—The decision of the Council upon questions of ethics or members' standing in the society and upon complaints and charges of misconduct as mentioned in this article shall be final, unless upon report of its action to the society the latter shall resolve by a majority vote of the members present to take the case out of the jurisdiction of the Council for general discussion and for action of the society as a whole."

SCIENTIFIC

The Scientific Program was on syphilis, and was arranged by the Public Health Committee, Dr. Edward C. Klein, Jr., Chairman.

Robert R. Sellers, Director of the Venereal Disease Clinic, Newark Board of Health, described the incidence of the disease in the city, and the efforts of his department to serve the community and the profession to further its control and eradication.

Dr. A. J. Casselman, Director of the Venereal Disease Division of the New Jersey Department of Health, described the functions of the State Agency to serve the public both directly and through the Medical Profession.

Dr. Charles V. Craster, Health Officer of Newark, opened the discussion with interesting comments on the history of syphilis and presented some important statistics.

NEW MEMBERS

The following members were elected:

Regular: Sidney Cohen, Emanuel Denholtz, William Michael Epstein, Philip Levine, Charles Margulies, Sylvester Prestofilippo, Margaret M. Wurts.

Associate: H. Lawrence Sutton, John J. Torppey.

REPRESENTATION ON COUNCIL

Following the comments and suggestions made by Dr. John F. Condon in his address at the close of his presidential year recommending a different method of representation on the Council for the doctors in the suburban communities, a committee was appointed to study the subject. Dr. Condon was made chairman, and with the help of A. Ambrose, H. N. Comando, W. D. Crecca, J. T. English, E. A. Flynn, R. D. Freeman, W. K. Pudney, H. R. Van Ness and F. C. Weber, the following reports are now recommended to the society:

At the annual meeting of the County Society in October, 1935, it was recommended that the President appoint a committee to study the advisability of dividing the county into districts, and electing one or more Councilors from each district rather than from the society at large, as has been the procedure for some time past.

This recommendation was based on the sound premise that the Council is the representative body of the whole society. The By-Laws state that "it shall give studious attention to the progress and reasonable problems of the profession and consider all necessary matters among physicians and between the profession and the community".

Such a committee, known as the Committee to Study Representation on the Council, was appointed by the then President of the Society, Dr. A. Charles Zehnder, and reappointed this year by Dr. Edgar A. Ill. This is the report of this committee to the society.

The committee first studied the geographical distribution of society members, and prepared a map of the county showing the location of each member. On the basis of current membership, this reveals that 517 regular and forty-one associate members are within the city limits of Newark; and that 391 regular, including nineteen in Hudson County, and thirty-five associate members are in the other municipalities of the county. Thus the membership of the society is almost evenly divided between the City of Newark and the remainder of the county.

The 334 physicians licensed to practice in the county who are not members of the society show roughly the same geographical distribution.

Analysis of the membership of the Council for the ten years preceding this reveals that at no time have the suburbs had more than two men on the Council. In other words, the City of Newark, with approximately half the membership of the society, has always had at least three-fourths of the representation on the Council.

It seems obvious that if the Council is to carry out the mandate of the By-Laws to be responsible for the welfare of the *whole* profession and for the relations between the profession and the community, it must be composed of men who are conversant with the problems in all of the twenty-two municipalities that constitute the county.

Your committee, therefore, unanimously recommends that:

1. The county be divided into five districts as listed below, with the number of members in each district.

District No. 1—			
Newark	517 active,	41 associate	—total 558
District No. 2—			
Irvington	33 active,	3 associate	
Maplewood	16 active,	2 associate	
Millburn	3 active,	1 associate	
So. Orange	21 active,	1 associate	
Orange	34 active,	4 associate	
			—total 118
District No. 3—			
Livingston	2 active,	0 associate	
Caldwell	10 active,	0 associate	
Cedar Grove	6 active,	0 associate	
Verona	7 active,	1 associate	
Montclair	70 active,	3 associate	
Roseland	1 active,	0 associate	
			—total 100
District No. 4—			
Glen Ridge	1 active,	0 associate	
Bloomfield	26 active,	3 associate	
Belleville	13 active,	2 associate	
Nutley	13 active,	1 associate	
Hudson Co.	15 active,	4 associate	
W. Orange	10 active,	2 associate	
			—total 90
District No. 5—			
East Orange	110 active,	8 associate	—total 118
Total membership			984

2. In future, the Council of the society be composed, at all times, of eight members elected by the entire society as follows: Four from District No. 1 and one from each of the other four districts.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

Dr. E. L. Eliason, Professor of Surgery at the University of Pennsylvania Medical School, was the principal speaker at the January meeting of the *Gloucester County Medical Society* held the evening of January 21 in the Georgian Room at the Homestead. He gave an interesting, practical talk on "End Results of Cholecystectomy".

NEW MEMBER

Dr. A. Guy Campo, of Westville, was elected to membership.

SUPPER

A buffet supper, at which the members of the Ladies' Auxiliary were guests, was served at the close of the meeting.

ATTENDANCE

The attendance of thirty was the largest in several months, with the following members present: Drs. William E. Crain, Ralph Moore, Dorothy Rogers, J. F. Hughes, William Brewer, H. B. Diverty, Paul Burkett, Paul Pegau and E. E. Downs, Woodbury; B. A. Livengood, Swedesboro; H. W. Wright, W. J. Burkett, M. E. Lummis and I. W. Knight, Pitman; William G. Harris, Mullica Hill; C. I. Ulmer, I. N. Patterson, Gibbstown; C. C. Sheets, H. L. Sinexon, Oran A. Wood and Anthony DiMarino, Paulsboro; W. W. Pedrick and Ralph Venturo, Glassboro; Don Weems and R. D. Zapf, Wenonah; H. M. Fooder, Williamstown; R. K. Hollinshed, Westville; and Louis Ruttenberg, Mantua.

Visitors included Drs. Oram Kline, Edwin R. Ristine and C. Herbert Johnson, Camden County Society; and Dr. Hollinger, of Clayton.

HUDSON COUNTY

J. M. Connell, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held on Tuesday, January 5, 1937, at the Carteret Club, and was called to order by the President, Dr. J. Lawrence Evans, at 9:30 p.m.

SCIENTIFIC SESSION

Dr. J. L. Evans introduced Dr. C. P. Rhoads, Associate Member of Rockefeller Institute, who spoke on the subject "Anemia". The discussors: Drs. Alter, White, Pearlstein, Macchia, Schuck, Donnelly. Discussion closed by Dr. Rhoads.

Dr. Evans also introduced Dr. E. Zeh Hawkes, Second Vice-President of The Medical Society of New Jersey, who described the "Activities of the State Society". Discussors were Drs. Shapiro, Norton, and Ruoff. The discussion was closed by Dr. Hawkes.

BUSINESS SESSION

President Evans called attention to the Annual Dinner, and said that last year there were 172 present, and hoped the number will be exceeded this year.

MEDICAL DEFENSE

The following communication was received from Dr. Christopher C. Beling, Chairman on Medical Defense of the State Society:

"At a regular meeting held on Monday, November 23, 1936, the Committee on Medical Defense passed the following resolution:

"That the Committee on Medical Defense ask The Medical Society of New Jersey to arrange with the component county medical societies for the appointment of Medical Defense Committees, consisting of not more than three members, to act in coöperation with the Committee on Medical Defense of the State Society in all matters pertaining to the protection of the interests of members, against whom malpractice suits may be threatened or instituted."

It was regularly moved and seconded that this proposal be referred to the Executive Committee.

MEMBERS OF MEDICAL STAFFS OF HOSPITALS

A communication was received from Dr. William D. Cutter, Secretary, Council on Medical Education and Hospitals, American Medical Association:

"Resolved, that it is the opinion of the House of Delegates of the American Medical Association that physicians on the staffs of hospitals approved for interne training by the Council on Medical Educa-

tion and Hospitals should be limited to members in good standing of their local county medical societies, and that the House of Delegates requests the Council on Medical Education and Hospitals to take this under advisement."

It was regularly moved and seconded that this be referred to the Executive Committee.

ACADEMY OF MEDICINE

The following communication was read:

"The Academy of Medicine of Northern New Jersey, an institute organized for the advancement of the science and art of medicine, extends a welcome to the members of the Hudson County Medical Society and an invitation to become Fellows of the Academy."

LIBRARY COMMITTEE

Dr. N. Alter: "Dr. Perkel brought up the question of a Library Committee. There were three members appointed to this committee and no action has been taken. I move that the Chairman appoint two extra members to the Library Committee."

Seconded and carried.

A. M. A. DECISION

Dr. T. J. Schuck asked if any report had been received from the American Medical Association in regard to the meeting held in Chicago last October.

Dr. Evans: "As far as I know there has been no word from Chicago. The committee meets quarterly and I feel that before this month is over we may hear from it."

WELFARE COMMITTEE REPORT

Dr. M. Shapiro quoted the following comparative rates for professional liability (malpractice) insurance, as obtained from Byron & Byron, Inc.:

UNITED STATES FIDELITY AND GUARANTY COMPANY
LUMBERMEN'S MUTUAL CASUALTY COMPANY
(Non-assessable Policy)

Limits		
5/15,000	$24.00	$16.00
10/30,000	25.00	21.92
20/30,000	30.00	27.20
20/40,000	32.00	28.32
25/50,000	35.75	30.88
25/75,000	38.75	32.00

Re: Lumbermen's Mutual Casualty Company.

The above rates are basic rates, excluding use of physical therapy equipment or x-ray for diagnosis.

Including x-ray for diagnosis only and physical therapy equipment, the basic charge is $21.00.

For each specialist in major surgery, including use of x-ray for diagnosis only and physical therapy equipment, the basic charge is $32.00.

For each regular assistant: Fifty per cent of the rate applicable to the employer.

(This charge is made under the employer's policy, and the names of the assistants are shown in the proper statement of the schedule. An assistant is a physician, surgeon, dentist, anesthetist or x-ray technician. No charge is made for nurses or non-professional attendants. No additional charge is made on employer's policy for assistants, if assistant has a policy for himself with this company.) Policyholders also participate in a dividend, at present 20 per cent of the premium, payable at the end of the policy year.

The committee reported progress and will have a definite report at the next meeting.

COMMITTEE ON CONSTITUTION AND BY-LAWS

The following new amendment to the Constitutions and By-Laws was adopted to the following effect:

"The provisions creating Associate Members in the Hudson County Medical Society be deleted from the By-Laws and that all references to such membership be stricken from all sections of the By-Laws.

"We find that deleting Section 1 (b) from Chapter 1 of the By-Laws would have the effect of making all present Associate Members Active Members, and this would, in turn, mean that all present Associate Members would have to pay the regular dues of $18.00 per annum.

"The committee, therefore, feels that Section 1 (b) of Chapter 1 should be retained.

"The committee feels that a Section 1 (c) should be added to Chapter 1 as follows: Section 1 (c): Any Associate Member of the Hudson County Medical Society who is an accredited member of a hospital staff in the County of Hudson, and any other Associate Member may apply for Active Membership at any time prior to the termination of the two-year probationary period. The manner of his election into Active Membership shall be by vote of the society at any regular meeting, upon recommendation of the Board of Censors.

"The dues of members so elected shall be the same as those of all Regular Active Members of the society and their rights and privileges shall be those of a Regular Ative Member."

Dr. M. Shapiro asked about the present list of Associate Members.

Dr. Ruoff: "The present Associate Members may become Active Members, or serve their probationary period as an Associate Member. No new Associate Members will be admitted, the difference being that an Associate Member cannot be on the staff of a hospital."

Dr. Shapiro: "Does the American Medical Association recognize Associate Members?"

Dr. Evans: "No, they do not."

Question was called, and the amendments were adopted.

DATE OF ANNUAL MEETING

Dr. A. C. Ruoff: "The Secretary tells me that it has been the desire of the Executive Committee that the regular meeting be changed from October to May. For this change to be made as usual, it would mean that the last reading would be in March. I feel that a motion would be proper at this time relative to the annual meeting. The change is as follows:

1. Amend the last sentence of Article 4 of the Constitution to read:

"The Regular Meeting in May shall be the Annual Meeting, at which meeting the election of officers shall be held."

2. Chapter III—By-Laws—Section 1 to read:

"The Officers, Delegates and elective committees of this society shall be elected by ballot at the Annual Meeting in May, and shall be installed immediately at the end of this meeting."

3. Change the first paragraph of Chapter III—Section 2 of the By-Laws:

"The Nominating Committee shall announce its nominations for the various offices at the March meeting and the membership shall be notified of them in the notiec for the April meeting. Additional nominations may be made from the floor at the April meeting. At the close of the April meeting no further nominations shall be made for the Annual Meeting."

4. Add Section 2 (d) to Chapter IV of the By-Laws:

"The Executive Committee shall have power to fill vacancies in all offices and elected standing committees until the next annual meeting."

5. Change Section 4 of Chapter IV of the By-Laws to read:

"The Nominating Committee shall consist of five members, elected at the Annual Meeting. The committee shall be nominated from the floor at the April meeting."

On motion of *Dr. J. Londrigan,* these amendments were referred to the Constitution and By-Laws Committee.

PROPOSAL OF NEW MEMBERS

Dr. Michael W. Agolia, 1347 Boulevard E., West New York; Dr. Louis A. Amdur, 834 West Side Avenue, Jersey City; Dr. Frank R. Arndt, 217 29th Street, Woodcliffe; Dr. Richard A. Cupaiuoli, 12 31st Street, North Bergen; Dr. Frederick William Dershimer, 546 Bergen Avenue, Jersey City; Dr. Henry R. W. Finn, 84 Lembeck Avenue, Jersey City; Dr. Casimir F. Gadomski, Medical Center, Jersey City; Dr. John G. Imhoff, 55 Lincoln Street, Jersey City; Dr. Charles A. Landshof, 27 Broadman Parkway, Jersey City; Dr. Anthony J. Saladino, 427 15th Street, Union City; Dr. Arthur B. R. Smith, 65 Tonnele Avenue, Jersey City; Dr. Harold Sussman, 326 24th Street, Union City; Dr. Juliana Swiney, 335 Avenue C, Bayonne; Dr. Edwin J. G. Valentine, 559 Summit Avenue, Jersey City; Dr. Eli A. Wallack, 333 Fairmount Avenue, Jersey City; Dr. Harry T. Aronowitz, 11 E. 42nd Street, Bayonne: Dr. Harry Feinberg, 73 W. 32nd Street, Bayonne; Dr. Emil H. Grieco, 196 Broadway, Bayonne; Dr. Peter D. Manno, 81 W. 25th Street, Bayonne; Dr. Louis Meltzer, 32 W. 33rd Street, Bayonne; Dr. Samuel J. Penchansky, 847 Avenue C, Bayonne; Dr. Eli Rubenstein, 79 W. 32nd Street, Bayonne; Dr. Edward F. Salmon, 74 Fairview Avenue, Jersey City.

Dr. Londrigan moved that they be referred to the Board of Censors.

Seconded. So ordered!

Dr. M. Leonard Kimmel, Jersey City, was elected to membership.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met at the Trenton Country Club on the 13th day of January, President D'Arcy presiding.

SCIENTIFIC

Dr. Sommer introduced the speaker, President-Elect William G. Herrman, M.D., of the State Society, who emphasized the necessity of a close watch being kept upon the activities attending legislation on the Social Security Act; and said that the Survey of Hospitals now being made under the direction of Dr. Lewis will be of great value in this connection.

The speaker stressed the point of disease epidemics being similar to the present psychologic epidemics which now appear to be in evidence, and referred to the transition in our forms of government beginning in the era of Feudal Lords, up to the present day of democracy, in which the universal health problem holds a most prominent place in our program.

Several questions were propounded by members present, all of which Dr. Herrman answered clearly.

SPEAKERS' BUREAU

Dr. Wilkes made the statement that 105 men, representing six counties, were ready to speak upon subjects best fitted for certain audiences, at the call of counties making such a request, and advocated additional numbers from this county.

Slides were shown by Dr. Wilkes, during the course of the address, outlining the working basis for all committee plans, as promulgated by President Snedecor.

MEMBERSHIP

The Treasurer moved that Drs. W. N. Rogers and T. A. Pierson be made honorary members. The motion was carried.

Drs. Anthony, Ellis, Engelhart, Epstein, Fabian, Fiorello, Hess, Kondor and Sutnick were elected to Active Membership; and Drs. Atkinson, Burbidge, Murto, and Tomec were elected Associate members.

The report of the Executive Committee with recommendations relative to the disposation of State Committee communications was accepted and approved.

MIDDLESEX RESOLUTIONS

The reading of resolutions adopted by Middlesex County (Jour., Jan., p. 63) created considerable discussion, and following remarks made by Dr. McGuire, in which the relative importance of such measures were definitely associated with the conduct of other counties in their management of the several subjects embodied therein, the motion was carried that the resolutions be referred to the Public Relations Committee for further study and enlightenment.

MEMORIAL TO DR. ADAMS

The President appointed Drs. Blackwell, Carl Pierson and Scammell as a Memorial Committee on the death of Charles F. Adams, M.D.

Notice of the Post-Graduate Institute of the Philadelphia County Medical Society to be held April 12th to 16th will appear in the Journal.

MIDDLESEX COUNTY

Charles H. Calvin, M.D., Reporter

The monthly meeting of the *Middlesex County Medical Society* was held Wednesday, January 20th, 1937, at The Pines, Metuchen, and was called to order at 9:30 p.m. by Past President Dr. J. J. Mann, in the absence of Drs. John H. Rowland, President, and J. V. Smith, Vice-President. Due to the inclement weather the attendance was small.

COMMUNICATIONS

A letter from Dr. McKiernan, regarding the legality of the appointments of certain committees as per Sections 7, 16 and 17 of our Constitution, was referred to the Committee on Constitution and By-Laws.

WORKMEN'S COMPENSATION

A letter from J. I. Fort, M.D., Chairman of the Compensation Law Committee of the State Society, was read, requesting information to complete a survey of the conditions in our county by answering the following questions:

1. Are the medical provisions of the law being enforced?
2. What are the defects in the present law from the medical standpoint?
3. What suggestions have you to remedy the conditions found in your study of questions Nos. 1 and 2?
4. Right of choice of injured to his own physician?
5. Medical referee for medical questions?
6. Bill adjustment committee, legalized?
7. Payment of medical bills by employers and Insurance Company?
8. State medical employees working for Insurance Company?

TRANSFER OF MEMBERSHIP

A letter from Theodore D. Spritzer, M.D., requesting transfer from Middlesex County to Sussex County Medical Society.

Dr. Spencer moved and was seconded that this request be granted, provided he has fulfilled the necessary requirements.

POST-GRADUATE INSTITUTE IN PHILADELPHIA

A letter was read from the Philadelphia County Medical Society inviting all members to attend the Second Annual Session of the Post-Graduate Institute of the Philadelphia County Medical Society in Philadelphia April 12th to 16th, 1937. The place of meeting is at Bellevue-Stratford Hotel, Philadelphia. Registration fee, $5.00. "Diseases of the Chest and Upper Respiratory Tract" will be discussed. A scientific exhibit as well as a technical exhibit will be displayed. Letter has been filed.

SCIENTIFIC

The scientific program was presented by Dr. Richard Kovacs, Clinical Professor and Director of Physical Therapy at Polyclinic Medical School Hospital, and author of "Electro-Therapy and Light Therapy", who gave a comprehensive survey of the clinical uses of the various physical therapy apparatus. The address was illustrated by lantern slides. He was heard with great interest and profit. It was discussed by Drs. Hauber, Rona, and Jacobson.

APPOINTMENT OF COMMITTEES

Since the last monthly meeting, President John H. Rowland has appointed the following committees:

Committee on Public Health
Dr. William London, Chairman
Dr. Samuel G. Berkow — Dr. F. H. Taber
Dr. C. H. Rothfuss — Dr. J. D. Witmer
Dr. H. Strandberg

ADVISORY COMMITTEES TO COMMITTEE ON PUBLIC HEALTH

Committee on Cancer Control
Dr. J. H. Kler, Chairman
Dr. F. M. Clarke — Dr. J. J. Jablonski
Dr. Frank Henry, Jr.

Committee on Mental Hygiene
Dr. I. E. Rineberg, Chairman
Dr. Geo. P. Boulden — Dr. Matthew Molitch
Dr. Melvin M. Hunt

Committee on Venereal Disease Control
Dr. Robert L. McKiernan, Chairman
Dr. S. E. Kramer — Dr. Bruce J. Massey
Dr. M. S. Brody — Dr. E. I. Cronk
Dr. A. A. Pansy — Dr. Wm. C. Wilentz

Committee on Study and Control—Appendicitis
Dr. H. W. Nafey, Chairman
Dr. G. R. Gessner — Dr. Benjamin Slobodien
Dr. Fred W. Scott

Committee on Study and Control of Blindness
Dr. Barth M. Howley, Chairman
Dr. P. E. Downing — Dr. Louis Wetterberg
Dr. Percy L. Smith

Committee on Maternal Welfare
Dr. James Grieve, Chairman
Dr. Samuel G. Berkow — Dr. R. L. Panogrosso
Dr. Marvin Dorothy — Dr. Fannie Sender

Committee on Child Health
Dr. J. S. Uhr, Chairman
Dr. Howard Dieker — Dr. C. J. Hofer
Dr. Ira H. Degenhart — Dr. Robert Pinnerman
Dr. H. P. Fine

Committee on Diphtheria and Smallpox
Dr. E. I. Cronk, Chairman
Dr. Antonio Fanelli — Dr. G. T. Longbothum
Dr. I. Goldberg

Committee on Study and Control—Heart Disease
Dr. Estelle Kleiber, Chairman
Dr. Imre Kemeny — Dr. Calvert R. Toy
Dr. Seldon T. Kinney — Dr. Louis Wetterberg

Committee on Study and Control of Deafness
Dr. N. B. Cohen, Chairman
Dr. I. J. Cooper — Dr. C. Falcone

ADVISORY COMMITTEES TO COMMITTEE ON PUBLIC HEALTH

Committee on Crippled Children
Dr. Charles W. Naulty, Chairman
Dr. L. S. Downs — Dr. Florentine Hoffman
Dr. E. H. Eulner — Dr. N. Szuch
Dr. Valentine P. Gauzza

Committee on Tuberculosis

Dr. Chas. I. Silk, Chairman

Dr. L. A. M. Feher — Dr. Murray B. Jacobson
Dr. Benjamin F. Glasser — Dr. E. A. Kovarsky
Dr. Sol Gurshman — Dr. M. J. Kraczyk
Dr. Eugene A. Hauber — Dr. B. M. Sirrott

ADVISORY COMMITTEES TO TUBERCULOSIS COMMITTEE

Dr. Charles I. Silk.....Tuberculin
Dr. B. F. Glasser..... X-Ray
Dr. M. B. Jacobson.....Publicity

Committee on Public Relations

Dr. W. E. Sherman, Chairman

Dr. Edward F. Klein — Dr. Adrian X. Urbanskl
Dr. J. H. Kler — Dr. J. Francis Weber
Dr. A. L. M. Smith

Committee on Coördination

Dr. Murray B. Jacobson, Chairman

Dr. Benjamin F. Glasser — Dr. Charles I. Silk

ADVISORY COMMITTEES TO COMMITTEE ON PUBLIC RELATIONS

Committee on Medical Care of Indigent

Dr. George W. Fithian, Chairman

Dr. H. B. Copleman — Dr. C. H. Rothfuss
Dr. Alexander Klein — Dr. Charles T. Steffen
Dr. John H. Reason — Dr. Benj. S. Van Dyke

Committee on Pharmaceutical Problems

Dr. C. F. Merril, Chairman

Dr. V. O. Lesh — Dr. Price T. Watson
Dr. Theodore J. Miller

Committee on Nursing and Nursing Education

Dr. Chas. W. Naulty, Chairman

Dr. S. Z. Nieman — Dr. Maurice Rona
Dr. J. H. Reason

Committee on Hospital Relations

Dr. Philip S. Avery, Chairman

Dr. Wm. Klein — Dr. J. Vincent Smith
Dr. John L. Lund — Dr. H. J. White
Dr. Eugene Meacham

ADVISORY COMMITTEE TO COMMITTEE ON PUBLIC RELATIONS

Committee on Medical Practice

Dr. J. S. Fagan, Chairman

Dr. A. Fishkoff — Dr. Jos. Gutkowski
Dr. N. N. Forney — Dr. A. Shayevita
Dr. S. W. Fox

Committee on Cantract Practice

Dr. F. Albert Donlon, Chairman

Dr. L. P. Runyon — Dr. Thomas Platt
Dr. S. M. Lazow — Dr. I. E. Rineberg

Committee on Programs and Arrangements

Dr. Estelle Kleiber, Chairman

Dr. George F. Leonard — Dr. Matthew Molitch

Committee on Compensation

Dr. J. D. Cottrell, Chairman

Dr. George F. Hilker — Dr. John F. McGovern
Dr. N. S. McLeod — Dr. Samuel J. Messinger

ADVISORY COMMITTEES TO COMMITTEE ON PROGRAM AND ARRANGEMENTS

Committee on Increasing Membership

Dr. L. S. Bassett, Chairman

Dr. S. Breslow — Dr. Nathan Karshmer
Dr. N. N. Forney

Committee on Post-Graduate Study

Dr. J. Vincent Smith, Chairman

Dr. L. H. Lief — Dr. William Stein
Dr. Wm. M. London

Committee on Increasing Attendance

Dr. F. J. Koelsch, Chairman

Dr. J. F. Anderson — Dr. James J. Collins
Dr. C. B. Burnett — Dr. E. I. Margarettan

Committee on Woman's Auxiliary

Dr. H. Haywood, Chairman

Dr. E. J. Csema — Dr. Pauline A. Long
Dr. H. C. Goldberg — Dr. M. F. Urbanski

On motion the meeting adjourned.

MONMOUTH COUNTY

O. R. Holters, M.D., Reporter

A meeting of the *Executive Committee* was held at the Monmouth Memorial Hospital, Long Branch, on Monday evening, January 11th, at 8.30. Those present were Doctors Rullman, Parry, Fisher, Pregnall, Kazmann, Holters, Herrmann, Blaisdell, and Featherston.

Correspondence from the office of the State Medical Society was read and ordered filed.

FEES FOR COMMITMENT TO STATE HOSPITALS

Letters were received from Dr. Joseph Carter and Dr. E. A. Robinson in regard to their bills for indigent patients for commitment to the State Hospital. The bills were rejected by Mr. J. L. Montgomery, County Adjuster, with the statement that the Board of Freeholders requested him not to O K the bills until some agreement had been made between the Board of Freeholders and the Medical Society.

The Medical Society had had representatlves meet with the Board in an effort to formulate a satisfactory agreement, but up to the present time no decision has been reached. The Secretary was instructed to again contact Mr. Montgomery in regard to this matter.

MEDICAL SERVICE BUREAU

Dr. James Fisher reported on the correspondence which he had with the Orange Memorial Hospital in regard to the organization of a Medical Service Bureau.

AMBULANCE AND SAFE DRIVING

A discussion took place concerning a recent automobile accident which involved an ambulance, and caused the death of the patient who was being transported to the hospital. The Executive Committee feels that the Monmouth County Medical Society should go on record with the statement that an ambulance is never justified in disregarding the motor vehicle laws.

TELEPHONE NUMBER

It was voted that the office of the Monmouth County Medical Society should be listed as such in the telephone directory.

DUES

To save the treasurer the unpleasant task of calling your attention to delinquencies, dues must be paid by January 23rd. The official list will be closed on this date. Send in your check now. $17.00.

The regular monthly meeting of the *Monmouth County Medical Society* was held on Wednesday evening, January 27th, 1937, at the Molly Pitcher Hotel, Red Bank, with Dr. Walter Rullman, president, presiding.

RESIGNATIONS OF MEMBERS

The resignation of Dr. George Halsey Hunt was accepted as Dr. Hunt has entered the U. S. Public Health Service in the capacity of Surgeon and has been ordered to Seattle, Washington, for duty.

Dr. Koner of the State Hospital at Marlboro also tendered his resignation which was accepted.

COUNTY GRANT TO HOSPITALS

A resolution was also adopted that the Monmouth County Medical Society present to the Board of Freeholders a request for an increase of funds for the several hospitals of Monmouth County, although they have recently been granted an increase of $50,000 over 1936. It was the sentiment of the society that the full quota of $250,000, as permitted by law should be granted.

INVITATION FOR ANNUAL MEETING

Another resolution was to invite the State Medical Society to hold its convention at Asbury Park for the year 1938.

VENEREAL DISEASE COMMITTEE

Dr. Clark read the report of Venereal Disease Committee in the absence of Dr. Blaisdell. Those serving on the same Committee are Drs. Wilkens, Perrotta, Jamison, and Carter. Emphasis was made on the necessity of coöperating with the U. S. Public Health Service in this work, and to secure for the members of the County Society the money designated for this purpose by the National Government.

Dr. Nichols related of his attending the National meeting of Venereal Disease Control at Washington, and stated that the American Medical Association, for the first time, was represented at a meeting of this kind. It was held under the auspices of the U. S. Public Health Service.

Dr. Nichols also pointed out the great necessity of coöperating with the government agencies so that organized medicine will continue to be the directing force in this work, rather than permit it to fall into the hands of politicians.

He also made mention of the fact that Dr. F. Jamison of Asbury Park was holding a part-pay clinic once a week at his office.

Dr. Nichols moved that the Venereal Control Committee's work be approved by the Society, which was done.

Dr. Max Silverstein of Asbury Park protested the establishment of these clinics, holding that they were offering competition to the General Practitioners.

SCIENTIFIC

Dr. Sands then introduced the speaker of the evening, Dr. W. H. Schmidt, Director of Physical Therapy, Jefferson College, Philadelphia, who presented a paper entitled "Things New in Physical Therapy".

He described the physics of diathermy, both the long and short wave. He indicated that short wave had its greatest use in the treatment of infection and carbuncles; and for other conditions it was vastly over-rated.

He also spoke on the newly developed fever therapy, and claimed that the electrical methods were too dangerous for general use, and the best results were obtained by vapor and heat baths. Conditions treated with this modality were: syphilis of the central nervous system, multiple sclerosis, asthma, gonococcal infections, and some types of optic atrophy.

He also spoke on the use of galvanic current for purposes of ionization and mentioned the excellent results obtained in treating chronic otitis media, vaso-motor rhinitis, and hay fever.

He ended his paper by discussing the uses of dessication in the treatment of surface malignancies, which he illustrated with lantern slides.

The paper was discussed by Dr. William Guillium of Asbury Park; and also by Norman Titus, of New York, who belittled the use of the short wave therapy, and belabored the commercial representatives of various electrical apparatus manufacturers for their high pressure salesmanship talks.

The meeting was adjouned about 11.30 P. M.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A regular monthly meeting of the *Morris County Medical Society* was held at All Souls Hospital, Morristown, on the evening of Thursday, January 21, 1937.

Secretary Young called the meeting to order, in the absence of the President and Vice-President because of illness. Considering the weather conditions and the prevalence of colds, etc., the attendance of about 55 was very encouraging.

Routine business included an announcement that the February meeting would be another non-medical or non-scientific meeting, this being justified by the increased attendance and marked popularity of similar previous innovations.

SPEAKERS' BUREAU

The purpose and functions of the "Speakers' Bureau" of the Welfare Committee of the State Society were explained. The Executive Committee announced that it had appointed Doctors Young and Earp as a committee to list the names of members who would be willing to be placed on the list of the "Speakers Bureau", and give talks to lay organizations on medical topics. The State

Society now has a list of 105, but Morris is one of the few counties having no one on the list. A recent request came from a local lay organization for a speaker on Venereal Diseases, who was furnished through the Speakers' Bureau.

DUES

Attention also was called to the payment of dues to Treasurer Harrington by February 1, 1937, the final date for closing the official membership list, and impressing the effect of non-payment of dues on the number of accredited delegates to the State Society.

SCIENTIFIC

The direction of the meeting was then turned over to Doctor Geary of All Souls staff for the scientific chapter.

Dr. Teller and Dr. Young presented two cases of unusual blood pictures in which definite diagnosis could not be made, and in which intense study failed to reveal any definite diagnostic leads. One case that died was given a tentative diagnosis of *splenic anemia,* the other case being considered of *unknown origin.* The presentations of histories and findings, illustrated by screen and pictures, showed that an enormous amount of work had been done, and consideration given to a variety of factors, but without leading to anything definite, this including the post mortem findings on the case that died. Possible causes and conclusions were quite generally discussed and altogether the meeting proved of much more than usual interest, from the standpoint of medical science.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held at the Health Center, Paterson, Thursday, January 14, 1937, at 9 p. m., with the president, Dr. Norman Dingman in the chair.

NEW MEMBEBRS

The following applicants for membership having been approved by the Board of Censors were unanimously elected to membership:

Dr. William Weintraub Dr. Victor Desmet

Junior Membership:

Dr. George A. Bradasch

COMMITTEES

At the request of the State Society, the President appointed the present Board of Censors, namely Dr. Joseph V. Bergin, Dr. Harry S. Willard, and Dr. Wright MacMillan, to act as a committee on Medical Defense and Grievances.

The following members were appointed to serve as the Committee on Public Relations:

Dr. Fred Vosburgh, Chairman

Dr. John Ryan
Dr. Frederick P. Lee
Dr. Lester F. Melony
Dr. Louis Shapiro
Dr. George E. Tuers
Dr. Charles J. Murn
Dr. Hyman J. Udinsky
Dr. James R. Lomauro
Dr. Wright MacMillan
Dr. Sigurd W. Johnsen
Dr. Theodore K. Graham

The following Committee on Cancer Control was appointed:

Dr. Louis G. Shapiro, Chairman

Dr. John H. Carlisle Dr. John Ryan
Dr. Thomas A. Clay Dr. Frank William Ash

Dr. Dingman then called for nominations from the floor for trustees for the Medical-Dental Service Bureau. Five nominees are to be submitted to the Board of Trustees who then elect three to serve for a period of one year. The following nominations were made:

Dr. Edward A. Atwood Dr. Fred Vosburgh
Dr. Frank William Ash Dr. Louis G. Shapiro
Dr. Henry Cogan

The following resolution was passed:

Resolved: That the Passaic County Medical Society hereby authorize the Board of Trustees of the Medical-Dental Service Bureau to extend its facilities and services to the members of the Bergen County Medical and Dental Societies.

SCIENTIFIC

The scientific session was then opened with a paper, "Treatment of Lobar Pneumonia" by Dr. Russell L. Cecil, of New York City. As is usual with Dr. Cecil, he gave a splendid talk on the latest methods of diagnosis and treatment of Lobar Pneumonia.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The regular meeting of the *Warren County Medical Society* was held at the Elks Club, Phillipsburg, Tuesday afternoon, January 19, at 3.30 p. m., and was called to order by the President, Dr. William Varney of Washington, with 15 members and guests present.

WARREN HOSPITAL

Mr. George B. Arnold, secretary of the board of Trustees of Warren Hospital, gave a brief resume of the work done in the hospital during the past year.

The need of a new modern hospital was stressed by several of the physicians present.

CANCER IN WARREN COUNTY

Dr. J. H. Kler of Rutgers University was introduced by the President as the guest speaker who spoke on cancer control. He compared the death rate of Hunterdon, Mercer, Somerset, Middlesex and Warren counties with the death rate in this state. It was shown that the death rate from cancer in Warren County was somewhat higher than the death rate in the state. This was attributed to Warren County being rural, patients neglecting to seek the advice of a physician in the early stages.

PEDIATRIC LECTURES

It was moved and seconded that the Warren County Society join Hunterdon County Society in a course of lectures on Preventive Pediatrics sponsored by the Child Welfare Committee of the State Society. The lectures to be given in April, preferably at Mt. Kipp.

THE WOMAN'S AUXILIARY

THE ANNUAL MEETING

The Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey is an opportunity for the organization to make an essential contribution to that of The Medical Society of New Jersey.

In the first place, the presence of the members of the Auxiliary will promote that good fellowship among the physicians which is one of the principal objectives of the Annual Meeting of the State Medical Society. It will be of mutual advantage to both the physicians and their wives to come together, and to share in a better understanding of the problems and aspirations of each group.

In the second place, the members of the Auxiliary have a definite field of service in conducting their exhibit of their avocations and those of their husbands. Every physician needs an avocation for the relaxation and recuperation which it will bring.

In the third place, the members have an opportunity to discover and preserve historical and geographical data regarding the former practitioners whose heritage is shared by every physician and every citizen of New Jersey. The Department of Medical History will doubtless become one of the most valuable features of the exhibit of the Auxiliary.

POPULAR PUBLICITY

The Medical Society of New Jersey is rapidly developing a corps of volunteers who are ready to address lay audiences on health subjects, and have over 100 already enrolled. The members of the Woman's Auxiliary can render essential service by making engagements for the speakers to address groups of women. The officers of the Auxiliaries will doubtless hear from Dr. Kler, Chairman of the Committee on Public Relations, in regard to the subjects and details of the delivery of the proposed lectures.

EXECUTIVE BOARD MEETING

By Mrs. Dan S. Renner, Skillman, N. J., Recording Secretary

The regular open meeting of the *Woman's Auxiliary to The Medical Society of New Jersey* was held at the Young Women's Christian Association in Trenton, Monday, January 11th, at eleven o'clock, Mrs. George A. Rogers, the President, presiding, and seventy-five members present.

INSURING THE AUXILIARY FUNDS

The Treasurer's report was read and approved. It showed a balance in the General Fund of $181.96; in the Annual Meeting Fund, $139.55. The Treasurer, Mrs. McConaghy, asked for consideration of insurance on the money she would handle during the Annual Meeting. After some discussion as to just what amount of money might be handled, the length of time the insurance would cover it, etc., Mrs. Surran moved that insurance be taken out to protect this money. Mrs. Don Epler seconded the motion. Mrs. Rogers stated that the rate of between ten to fifteen dollars per one thousand dollars for a period of two months was the lowest rate that could be found. Since the meeting this was corrected by Mrs. Rogers to three to six dollars. After more discussion, Mrs. A. Haines Lippincott moved that the motion be laid on the table until after luncheon. This was seconded and carried.

FEDERATION OF WOMEN'S CLUBS

A letter from the State Federation of Women's Clubs, containing a nominating blank, was discussed. Nominations for two offices were made. Mrs. Lippincott nominated and Mrs. Casselman seconded the nomination of Mrs. D. Trueman Stackhous for Vice-President for the First District; Mrs. William H. Osborne was nominated by Mrs. Epler and seconded by Mrs. McGuire. Both of these motions were carried.

N. J. SANITARY ASSOCIATION

A letter asking our Auxiliary to join the New Jersey Health and Sanitary Association was read. Mrs. Casselman explained that the Association is a Legal Health Association, and was doing a splendid work. Mrs. Lippincott moved that we join the Association, and that the President appoint a representative to attend the meetings. Carried.

RADIO PROGRAMS

Mrs. Holcombe, National Chairman of Program, asked that we distribute the Radio Program announcements in libraries, doctors' offices, public schools, etc; and that each member write for these programs and make good use of them.

Mrs. Rogers suggested that the members ask their County Presidents if they have received these posters, and then assist in their distribution.

RESIGNATION

Mrs. Frank Facciolo tendered her resignation as Chairman of Public Health, because of unforeseen circumstances which had arisen. It was accepted with regrets.

EXHIBIT

Mrs. Ily Beir, Chairman of Arts and Hobbies, read a copy of a letter which she had sent out to all the counties, explaining the method and reasons for the collection of data for the Exhibit at the Annual Meeting.

ANNUAL MEETING ENTERTAINMENT

Mrs. Carl A. Surran, Chairman of Entertainment, presented some suggestions from Dr. Kaighn for spreading the entertainment for the Annual Meeting over a longer period of time. The following suggestions were discussed:

1. That the bridge party be held on Tuesday night.
2. That the roller chair rides be given on Wednesday afternoon.
3. That the dance be held on Wednesday night.
4. That the luncheon be held on Thursday.

It was thought that this plan might attract more people; and that, if the women enjoyed the program, they might be the means of drawing more physicians to the medical meetings and keeping them there for the entire session.

Mrs. Lippincott suggested that the Auxiliary should make arrangements to adjourn for the President's address.

CARD PARTY

Mrs. Casselman, in discussing the question of the card party, stated that unless the program was interesting to everyone it would not be a success. Mrs. Curran explained that no one should feel obligated to come, that if anyone wanted to do anything else, they should feel free to do so; but that those who enjoyed playing cards would be entertained, thus making it a free night for everyone.

It was then decided that Mrs. Surran should make her plans as she had presented them.

HISTORY OF AUXILIARIES

The Historian, Mrs. James Hunter, reported that, except for what she had received from Burlington and Hudson Counties, she had nothing for her "Book of Memories".

Mrs. Rogers asked that, before the next meeting, each county should send to Mrs. Hunter statistics of its history up to date; also that Mrs. Hunter map out a plan whereby her work might be made more efficient, and estimate the amount of money which might be needed for this.

Mrs. Hunter stated again that we should have a steel cabinet in which to file these records.

HYGEIA

A letter from the National Chairman of Hygeia suggested plans for a contest in the sale of subscriptions for Hygeia.

ORGANIZING NEW AUXILIARIES

Mrs. Don Epler, Chairman of Organization, reported that she had had practically no success in organizing new counties, and asked for suggestions from the Auxiliary. She would like to send out extra copies of Dr. Wilkes' letter with a questionnaire which she had arranged, if this met with the approval of the Board.

She read the questionnaire, which was approved, and she was advised to send this to the counties.

Mrs. Rogers explained that she had also sent out a questionnaire very similar, but had not received complete replies; that each county should have a complete index file and keep it complete.

A motion was requested that Mrs. Epler send out the letter and questionnaire; this was seconded and carried.

PUBLICITY

Mrs. O. R. Carlander, Chairman of Press and Publicity, gave a very splendid report of her activities, some of which are:

The sending of letters to each county asking for material for The Journal. In October there were twelve responses, some of which were sent directly to The Journal. In November there were only two. This was partially explained by the fact that some Auxiliaries do not meet every month.

She sent reports to the *Herald Tribune* and the *New York Times,* but had not been able to get the clippings. She asked that anyone seeing these articles please send the same to her.

She had sent the list of names of the Speakers' Bureau to "The New Jersey Club Woman"; and to the National Auxiliary, pages from the Medical Journal, Mrs. Beir's report of Arts and Hobbies, and our Auxiliary Program.

She remarked that one paper asked that news be sent as advance news, and she thought that it would be of more interest to read of what is *going to happen* instead of what had happened.

Mrs. Rogers requested that each Board Member send in to Mrs. Carlander at least one clipping before our March meeting.

PUBLIC RELATIONS

Mrs. Lippincott, Chairman of Public Relations, stated that her report was late because she had waited for the list of the Speakers' Bureau, and for the Five-Minute Talks.

Mrs. Rogers explained that these talks could be had by contacting the present Public Health Chairman of Hudson County.

Mrs. Lippincott said that she had literature concerning her program, and requested that each County President or her representative take this back to her respective county. She had talked with Dr. Wilkes about the plan of having mimeographed copies of the National Program sent out to each county, and as a consequence these copies will be made and sent out.

APPROVED LIBRARY BOOKS

The list of books approved by the American Medical Association was presented to Miss Sarah Askew, State Librarian, who was sending one to each library in the State, to be posted on the bulletin

boards. She asked that we check up on our respective libraries to see if this list was posted.

Mrs. Carlander asked if this list could be published in The Journal. Mrs. Lippincott thought it a good idea, and would take the matter up with the Editor.

YEAR BOOK

Mrs. Rogers then presented her plan for a Year Book. This was heartily approved by the Executive Board.

Mrs. Corbusier moved that such a year book be published. This was seconded and carried. Such a book will be sent out to each Auxiliary member.

CRIPPLED CHILDREN

A delicious luncheon was served at 12:50 p.m. at the Young Women's Christian Association, planned by the *Mercer County Auxiliary.*

Joseph C. Buch gave his talk on "Helping Cripples to Help Themselves". The attentiveness of every member of his audienec was proof of his clear and understanding presentation of his subject. The questions which followed showed a deep interest in a problem which New Jersey is reported to be handling in a most efficient manner.

Miss Leontine Donini, accompanied by Mrs. Alvin S. Rogers, then gave several delightful vocal selections which were enjoyed immensely.

COUNTY REPORT

The Board then returned to business, hearing first the reports from the various counties, the gist of which will be given as follows:

Atlantic, with eighty-one regular members, seventy-two paid-up members, was making a survey to ascertain how many of the book lists had been read.

Burlington had had one meeting since December; its next meeting would be held in March. It is planning a reciprocity meeting soon.

Camden would hold its next meeting in March, the subject for discussion to be "Cancer". Its Reciprocity Meeting would be in April.

Essex reported a reciprocity meeting for January 25th.

Mrs. Rogers asked that each county having a reciprocity meeting to send invitations to other counties to attend.

Middlcsex, our baby Auxiliary, reported progress.

Somerset had held its first meeting in October, at which time the members were guests of the County Medical Society at its Annual Dinner.

The December meeting was addressed by our State President, Mrs. Rogers.

Hudson reported monthly meetings; a pamphlet published each month and sent to each member; a card party to raise a fund for this project; a supper dance, inviting the physicians; and a May Day program. It has been successful in presenting the "Five-Minute Talks" before fifteen lay organizations. It has a medical library, and has added to it the books on the approved list.

REPORT OF PRESIDENT-ELECT

The report of the President-Elect, Mrs. Samuel L. Salasin, was read by the Recording Secretary. It consisted of a résumé of some of her activlties during the existence of the State Auxiliary, and a commendation for those who had helped her in these activties.

PRESIDENT'S REPORT

Mrs. Rogers, our President, presented a general report of her year just passed, and some of her plans for the balance of the year. She called to our attention a paper on Social Security, written by Dr. Morrison. She requested each County President to write for a copy of it, and have it read before the members. It takes one-half hour to read, and is very interesting and enlightening (p. 114).

She asked if it were possible to present at the March meeting a program for the year to be given to the counties in order that the counties might begin, immediately in the Fall, to carry out these plans, making it unnecessary to await instructions from the State Board.

Mrs. Lippincott stated that, as the Auxiliary Program is more or less a repetition, there can be little change in it from year to year.

Mrs. Rogers asked that the counties please have the names of their chairmen ready to present to the State President in April. She also said that she would see the National President soon, and would talk over tentative plans with her.

She had had the pleasure of visiting Essex, Burlington, Somerset and Middlesex Counties at the time of their regular meetings, and had found them interested, and anxious to carry on any work they found possible.

Mrs. Lancelot Ely, Chairman on Resolutions, had sent a note of regret that she was unable to attend the meeting.

ART, HOBBY AND HISTORICAL EXHIBIT

Mrs. Ily Beir reported that in order to continue to make a success of the Arts and Hobbies Committee, money must be appropriated to rent show cases and to supply proper lighting for paintings. Some doctors had been reluctant to show pictures with such poor lighting as had been used heretofore. She estimated that the sum of $150 would be needed for this purpose.

INSURANCE OF FUNDS

Mrs. Lippincott moved that the motion pertaining to the insurance to cover funds handled by the Treasurer at the Annual Meeting be taken from the table. This was seconded and carried.

She amended the motion of the morning, to add "that the money be taken from the Annual Meeting Fund to pay this insurance". This was seconded and carried.

A motion was made, seconded and carried that insurance be taken to cover the funds handled by the Treasurer at the Annual Meeting.

Mrs. Epler announced that she was perfectly willing to prepare files of membership, but she could do this only with the coöperation of each county in answering her questionnaire. That she had been asked to visit Hunterdon County, but that she had no funds with which to do this. Dr. Wilkes assured her that the Medical Society had a fund to take care of this.

The meeting was adjourned until March 8th.

Clara C. Renner, *Recording Secretary.*

A. M. A. RADIO PROGRAM

The A. M. A. Radio Program is on the air on Tuesday afternoon; and again the doctors have solicited our assistance in building up a large listening audience.

This year we wish to place in every doctor's office, when agreeable to the doctor, a small poster telling of the A. M. A. Health Hour over the radio. These posters may be ordered directly from Dr. W. W. Bauer, 535 N. Dearborn Street, Chicago, Ill. State the number you want; print name and address plainly.

In addition to placing these posters in every doctor's office, we wish to encourage you to place a poster on the bulletin board in every school, club house, public library and other public buildings where you can get permission to hang one of these little posters.

Our work in publicizing the radio program was greatly praised by our doctors last year. Let us work even harder this year in building up the radio audienec to listen-in each week. Encourage each member of your Auxiliary to do likewise. Ask her in turn to tell others about the "Health by Radio" program which comes on the air each Tuesday afternoon put on by the A. M. A.

Please read the editorial in the October Hygeia.

MRS. E. V. HOLCOMBE,
National Chairman of Program.

Concrete work is given you to do.

In your report at the end of the year please state how many posters you used, and where they were placed.

MRS. G. A. ROGERS, *President,*
New Jersey Auxiliary.

COUNTY REPORTS

Atlantic County

Reported by Mrs. L. M. Walker, Atlantic City

Mrs. L. M. Walker entertained members of the Executive Board of the *Auxiliary to the Atlantic County Medical Society* at her home, 110 S. N. Carolina Avenue, on Tuesday, January 5th.

Plans were discussed for a Reciprocity Tea. This is an event inaugurated two years ago. It is held jointly by the local women's clubs, and is for the purpose of getting acquainted socially and with one another's various charitable and civic activities. Although no program has as yet been arranged, there is usually an interesting speaker and musical program, after which refreshments are served by members of the Auxiliary.

At the conclusion of the business meeting tea was served.

Present were: Mrs. Edw. F. Uzzell, Mrs. P. C. Joy, Dr. Winifred A. Blampin, Mrs. James H. Mason, 3rd, Mrs. David B. Allman, Mrs. Ely R. Beir, Mrs. Lawrence A. Wilson, Mrs. Carl A. Surran, Mrs. Clarence B. Whims, Mrs. G. Ruffin Stamps, Mrs. A. Merendino, Mrs. Morton Major, Mrs. Daniel C. Reyner, Mrs. W. Blair Stewart, and Mrs. L. M Walker.

The regular monthly meeting of the *Auxiliary to the Atlantic County Medical Society* was held Friday evening, January 8th, at the Ambassador Hotel.

At the suggestion of Mrs. David B. Allman, plans were made to raise money for our welfare fund by holding a raffle, the prize to be a small radio.

At the conclusion of the business meeting, Dr. H. L. Harley spoke on "The History of Medicine in Atlantic County". This is a subject with which Dr. Harley is thoroughly familiar, having spent a great deal of time and research on it in the past twenty years. Atlantic County will celebrate its 100th anniversary this year—having previously been a part of Gloucester County—and the Atlantic County Medical Society will celebrate its fifty-fourth birthday. At the time the County Medical Society was formed, Absecon was the big city in this vicinity. Dr. Job Summers was the first President of the Society. It was interesting to learn that his birthplace has recently been purchased by the Atlantic County Historical Society as a permanent museum. This house was erected in 1730, of bricks brought over from England in the hold of a ship to serve as ballast. These are but a few of the many interesting points brought to light by Dr. Harley's research.

Present at the meeting were: Mrs. Louis Feinstein, Mrs. Charles Hyman, Mrs. Edward H. Dyer, Jr., Mrs. Allan Rieck, Mrs. M. Browne Holoman, Mrs. Baxter H. Timberlake, Mrs. E. Harrison Nickman, Mrs. Abraham Krechmer, Mrs. Herman Kline, Mrs. Ily R. Beir, Mrs. David B. Allman, Mrs. G. Ruffin Stamps, Mrs. James MacFarland, Mrs. Clarence B. Whims, Mrs. M. Axilrod, Mrs. Morton Major, Mrs. A. G. Merendino, Mrs. William W. Hersohn, Mrs. L. M. Walker, Mrs. Daniel C. Reyner, Mrs. James H. Mason, 3rd.

Camden County

Reported by Mrs. George B. German,
Chairman of Publicity

The regular meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held in the form of a New Year's Tea at the home of Mrs. Joseph E. Roberts in Haddonfield on January 5th.

Dr. I. W. Knight, District Health Officer of the State of New Jersey, was the guest speaker, his subject being "The Social Security Act as It Affects the Medical Profession".

Following Dr. Knight's talk, a program was presented by Mrs. Lewis R. Dick, of Oak Lane, Pa., reader, and Mrs. James F. Boughton, of Camden, N. J., vocalist.

Mrs. Levi Hirst and Mrs. A. Haines Lippincott poured.

Gloucester County

NOVEMBER MEETING

Reported by Mrs. Fuller Sherman

A dessert bridge for the benefit of the *Woman's Auxiliary to the Gloucester County Medical Society* was held at the home of Mrs. C. A. Bowersox, on November 6th, at 1:30 p.m. The committee in charge were Mrs. C. A. Bowersox, Mrs. Paul Pegau, Mrs. E. E. Downs, Mrs. B. A. Livengood, and Mrs. C. I. Ulmer.

The regular monthly meeting was held Thursday evening, November 19th, 1936, at 9:00 p.m., at the Homestead Coffee Shop. The social committee were Miss Dorothy Underwood and Mrs. Ralph Moore. After a brief business meeting, the Auxiliary adjourned and the members joined the doctors at supper.

JANUARY MEETING

Mrs. Fuller Sherman, Reporter

The *Gloucester County Medical Auxiliary* held its regular monthly meeting Thursday evening, January 21st, at the Homestead Coffee Shop. Mrs. Ralph K. Hollinshed and Mrs. J. Harris Underwood were the social committee for the evening. Following the meeting the ladies joined the doctors for supper.

Hudson County

Reported by Mrs. Joseph Murray

A meeting of the *Auxiliary to the Medical Society of Hudson County* was held in the Y. W. C. A. in Jersey City on Monday, January 4th, at 2 p. m., with the President, Mrs. A. E. Jaffin, presiding.

Mrs. Jaffin opened the meeting and extended her best wishes for a Happy and Prosperous New Year to the Auxiliary and all its members.

Mrs. Louis Dodson, Entertainment Chairman, told of a card party to be held at the Y. W. C. A. in Jersey City on Wednesday afternoon, January 27th. She also said that the committee is planning a dinner dance to be held some time in April.

Mrs. Benjamin Macchia sent in a report on the five-minute health talks which are being given each month before lay organizations by members of the Auxiliary.

Mrs. James Murphy, Public Relations Chairman, reminded the Auxiliary of the dramatized medical talks being broadcast every Tuesday by the A. M. A. She urged the members to broadcast this information to their friends and relatives.

Mrs. William Freile, our Lending Library Chairman, reported that she had posted a list of books available, and asked for donations of others, both fiction and non-fiction. She stated that she had turned over to the Treasurer the sum of five dollars which the library has already earned. She asked the members to make use of the library, which is located temporarily in her home.

Mrs. George Culver asked for donations of clothing for Grossnor, a school in the mountains of North Carolina conducted by Dr. Martin and Dr. Mary Sloop.

Mrs. Long, Membership Chairman, reported an attendance of thirty-four members and two guests. She also introduced four new members, and presented a red rose to each. The new members are Mrs. B. B. Markowitz and Mrs. S. G. Scott, of Jersey City; Mrs. James L. Evans, of Woodcliff; and Mrs. Herman Comora, of West New York.

Mrs. Jaffin announced an open meeting of the State Auxiliary to be held in the Y. W. C. A. in Trenton on Monday, January 11th, at 10:30 a.m. She urged as many members as possible to attend the meeting.

The meeting then adjourned, and a most interesting talk on "Art in Gardening" was given by Miss Isabelle Haggerty, Principal of the Franklin School in Passaic. Miss Haggerty is also President of the College Women's Club in Passaic, and during Mr. Hoover's Administration served on the Child Health Conference at the White House.

Miss Haggerty began by saying that gardening is equally as great an art as music and painting. She said that the gardener can make beautiful something which has been unbeautiful. "Gardening is a matter of showing beauty in the things you handle," she stated. She spoke of the old herb gardens and showed a painting which she had made in Anne Hathaway's garden near Strafford on Avon, and also described the Stephen Foster Memorial Gardens which have been developed in our own country as a memorial to the American song writer. She also mentioned a lovely herb garden in Jersey City belonging to four sisters.

Miss Haggerty went on to say that, even though a garden should carry out one's own ideas, harmony is necessary in order to have it artistic. Some thought must be given to arrangement, color, order, and line.

"You can make gardening your hobby," she said, and told about some man who collected all types of gourds, and had a most beautiful collection of inside gardens in all shapes and sizes.

Miss Haggerty emphasize the fact that we can take the most common, everyday things and make beautiful gardens. As an example, she pointed out that common stones and common vegetable tops make beautiful inside gardens. She ended her most interesting talk with the statement that picking and arranging wild flowers is art in gardening, and then passed around some wild flowers which she had picked in one of our western states and mounted and covered with cellophane in order to preserve them.

The talk was followed by tea and a social hour. The hostess for the day was Mrs. William Freile, and she was assisted by Mrs. William Barbito, Mrs. John Machin, Mrs. Herman Jaffe, Mrs. Trugott Schuck, Mrs. Charles Peterson, and Mrs. William Stuart.

Middlesex County

Reported by Mrs. William H. McCormick,
Publicity Chairman

On Wednesday evening, December 16th, the *Woman's Auxiliary to the Middlesex County Medical Society* held its Annual Dinner and Installation Ceremonies at Pfaff's Restaurant in Metuchen.

In view of the fact that the Middlesex County Auxiliary had been organized but little more than a year, it was decided that the interests of the Auxiliary would be best served by retaining the same officers for one more year. The following officers were installed:

President, Mrs. John J. Mann, of Perth Amboy.
First Vice-President, Mrs. Herbert Strandberg, of Carteret.
Second Vice-President, Mrs. Marshall Smith, of New Brunswick.
Secretary, Mrs. William Stein, of New Brunswick.
Corresponding Secretary, Mrs. L. S. Downs, of Carteret.
Treasurer, Mrs. R. Faulkingham, of New Brunswick.

Mrs. Mann expressed her thanks to the officers and members for their effort and loyal coöperation during the past year, and outlined projects for the coming year.

The Auxiliary had as its guests for the evening Mrs. George Rogers, of East Orange, President of the State Auxiliary, and Mrs. Don Epler, of Newark, Chairman of the State Organization Committee, both of whom gave interesting talks on the work, aims, and organization of the Auxiliary.

After the dinner Mrs. Alice Gillis, of New Brunswick, a guest of the Auxiliary, entertained the members with a most interesting account of her experiences and adventures in war-torn Spain during the past Summer.

Further entertainment was furnished by Miss Alice Mezzaros and Mrs. Al Deen, of New Brunswick, who gave an exhibition of "Modern Magic".

Somerset County

Reported by Mrs. C. F. Halsted

A meeting of the *Woman's Auxiliary to the Somerset County Medical Society* was held at the Nurses' Home, Somerset Hospital, Thursday evening, December 10th, 1936. Eight members present.

Our President, Mrs. Gray, opened the meeting and asked for reports.

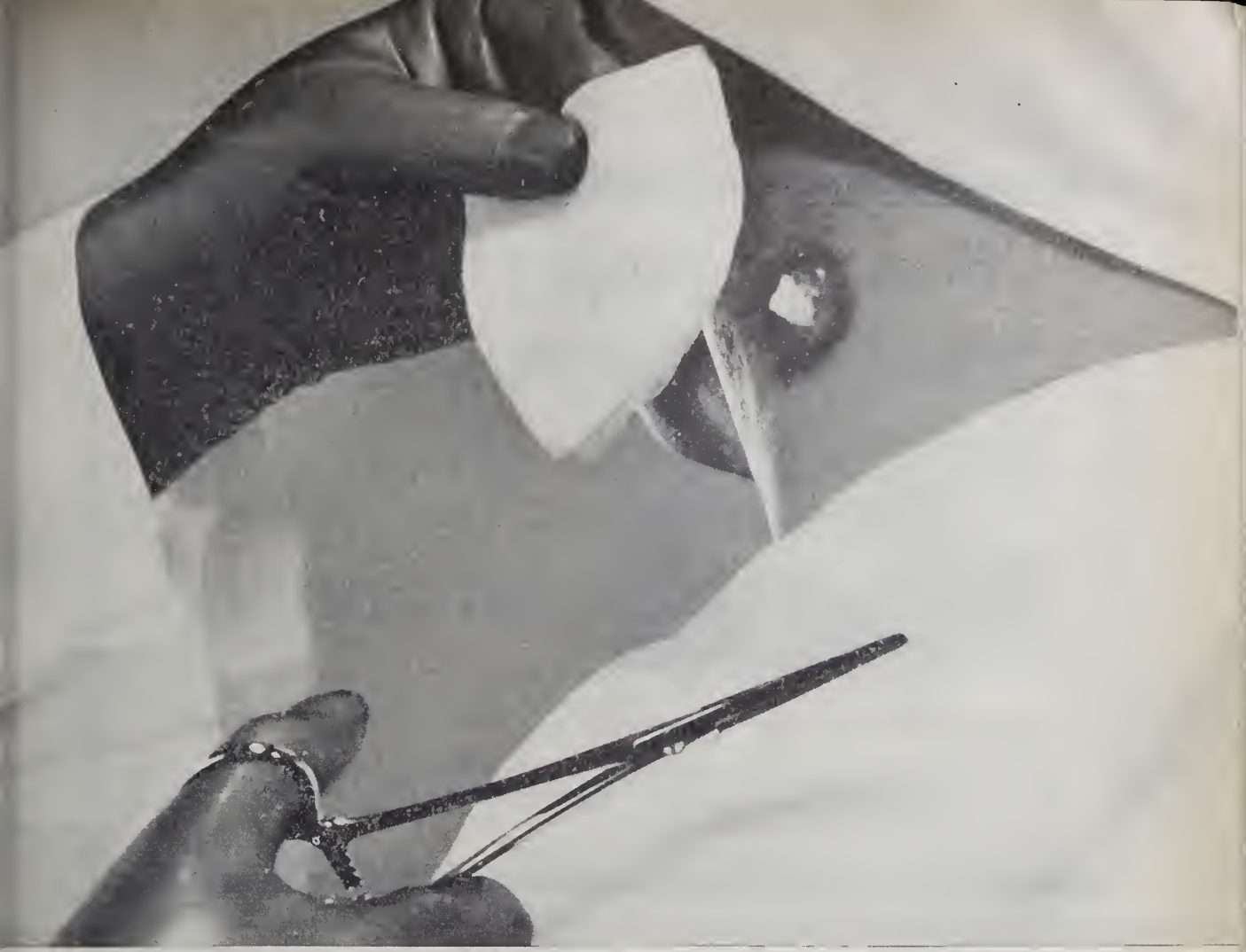
It was considered a fitting gesture to send two of our members, who are ill and shut-in, a basket of flowers for Christmas; also to send cards.

Mrs. Rogers, our State President, was our guest speaker. She said that a good program to follow was "Undertake less and accomplish more and further the aims and ideals of the Medical Profession". She also urged group attendance, if possible, at all public health meetings, for in this way a better impression would be made and the Auxiliary better known to the public. She also urged us to be in readiness to correct any mistaken ideas the laity might have received in regard to health education.

BOOK REVIEW

The Synopsis of Diseases of the Heart and Arteries issued through C. V. Mosby Company under the authorship of George R. Hermann is really a remarkable outline and summary of all the essential facts on the subject as accepted by cardiologists up to the date of publication early in 1936. Its excellence is maintained throughout, but if one were to favor certain chapters over others, they would probably be those on Radiologic Study of Heart Disease in ten pages and Electrocardiography in twenty-eight pages. Further condensation of the book would be at the sacrifice of valuable information, but nothing important is omitted. The extent to which the author has gone in recording practical detail is shown by the fact that in the discussion on differential diagnosis of mitral stenosis he cautions one to apply the bell of the stethoscope firmly to the chest in order to eliminate a pseudodiastolic rumble sometimes heard in an overactive heart. Unfortunately some readers will forget that this technic applies only to overactive hearts, and that at times a true presystolic murmur will be missed unless the bell is applied lightly. When differences of opinion exist, all the acceptable theories are given. For instance, although Hermann favors the view that the pain of angina pectoris is mechanical in origin, he describes also the chemical theory of Lewis and the anoxemia theory of Keefer and Resnik, the latter being favored by the majority. In the chapter on Congestive Heart Failure is a résumé of the early back-pressure or stasis theory and of Mackenzie's forward pressure theory. The former theory is now recognized as functioning in patients with the usual congestive type of heart failure, termed the dyskinetic syndrome; the latter, in those with acute circulatory failure, termed the hypokinetic syndrome; and the two in combination at times, termed the hypodyskinetic syndrome. The essential difference among these is tabulated in a chart taken from Harrison's recent book, "The Failure of the Circulation". Then follows an exposition on the biochemical changes ultimately responsible for heart failure. Some might differ from the author's opinion that rheumatic lesions never heal completely or that digitalis rapidly administered will usually strengthen the enfeebled heart action resulting from acute infectious diseases. One looks in vain in the chapter on Cardiovascular Syphilis for remarks on the narrowing of the coronary ostia to complete the important triad along with aneurysm and aortic valvulitis; true, its occurrence is mentioned in a few words in the chapter on Chronic Myocardial Insufficiency, but it deserves its own little paragraph in its rightful place. In a compend Paavo Nurmi does not deserve the distinction of being quoted as an exception to the rule that athletes do not have enlarged hearts. The fact that this is the extent of the reviewer's criticism, if it can be called such, is indicative of the author's medical orthodoxy. The discussion of peripheral vascular diseases, covering nine of the 311 pages of the text, is rather limited, but not more so than present-day knowledge of this field. The book measures 5" x 8" x ¾", convenient to carry around for perusal during odd moments, is printed in large type on good paper, and is supplied with a serviceable index. The ninety-one illustrations are well chosen. The author states in the preface that "this symposium is an attempt to provide an acceptable indexed epirome of the principles and modern conceptions of cardiologic practice • • • for the assiduous conscientious practitioner. To such physicians the excellent result of this attempt is highly recommended.

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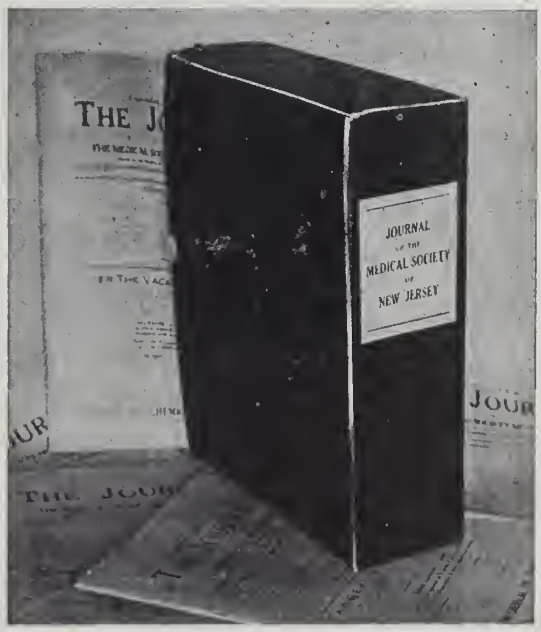
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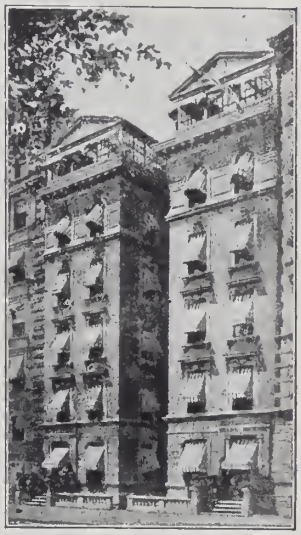
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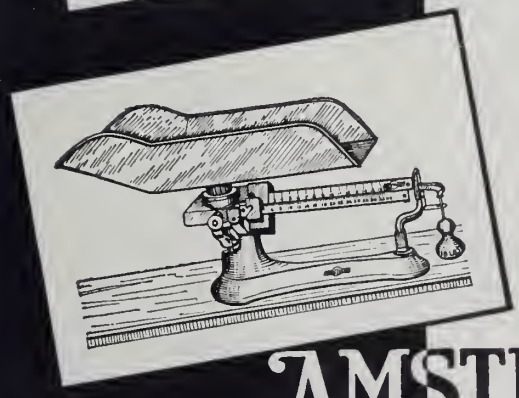
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GENERAL ELECTRIC X-RAY CORPORATION

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Most physicians agree upon the importance of cleanliness in milk for infant feeding. In ordinary cases, milk for babies may be regarded as satisfactory if it is reasonably clean.

Walker-Gordon Certified Milk is, if you will, "unreasonably clean." It is produced under conditions borrowed, in some respects from the technique of hospital hygiene.

For more than 40 years, Walker-Gordon has led in developing new processes—witness the Rotolactor—that have made possible a standard of cleanliness extremely high.

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Walker-Gordon Laboratory Company

Plainsboro, New Jersey



Scrambled train orders invite disaster. So in railroading as little as possible is left to memory. Train orders must be written!

Word-of-mouth prescriptions for vitamin products invite trouble, too. If confused or forgotten, the patient may get on the wrong track by selecting a deficient product. And because appearance, taste, smell or weight cannot help the patient to select wisely, low price may decide the choice instead of what matters—certainty of full vitamin content.

That is why many physicians make it a practice to write all their prescriptions for Haliver Oil with Viosterol, and to specify ABBOTT whenever vitamins A and D are indicated. In this way physicians can be sure that their patients will receive all those vitamin units they prescribed for them.

Abbott's complete control throughout production makes certain that only highest quality fish oil is used. Abbott's rigid bio-assays assure vitamin content true to label claims. Another very important assurance of quality is Abbott Laboratories' unique background of original research and manufacturing experience in the vitamin field.

Prescribe routinely for pregnant or lactating mothers, for children and any others who may need additional vitamins A and D. Available at prescription pharmacies everywhere in 3-minim capsules in boxes of 25, 50, 100 and 250. Also in 10-cc., 20-cc. and 50-cc. vials.

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ABBOTT'S HALIVER OIL with Viosterol

With a minimum of inconvenience to the patient...

ADEQUATE TREATMENT OF
PERNICIOUS ANEMIA
MAY BE OBTAINED BY THE USE OF

1 cc. CONCENTRATED SOLUTION LIVER EXTRACT
PARENTERAL

Lederle

THE CHOICE OF A LIVER EXTRACT for the treatment of pernicious anemia should depend primarily on the potency of the extract. Since treatment must be continued at definite intervals, it is also important to consider the discomfort caused by the injection of the extract.

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Available only in boxes of 3 vials—each containing one cubic centimeter.



LEDERLE LABORATORIES, INC.
30 ROCKEFELLER PLAZA NEW YORK, N. Y.

VITAMIN REQUIREMENTS OF MAN

I. VITAMIN C.

● Vitamin C is known to play an important role in human nutrition. Severe deficiency of this factor results in scurvy. It has been estimated by the Committee on Nutritional Problems of the American Public Health Association (1934) that the minimum daily intake of vitamin C (cevitamic acid) required to protect against scurvy increases from approximately 100 International units (5 mg. cevitamic acid) for the infant to 300 International units (15 mg. cevitamic acid) for the adult (1).

Vitamin C intake of this order of magnitude prevents the development of clinical scurvy, however, it is probably inadequate for optimum nutrition. Clear cut cases of scurvy seldom are seen in this country although some authorities believe that symptoms of a mild deficiency of vitamin C are not uncommon (2).

Referring to nutritional deficiency diseases in general it has been said that, "Almost every tissue in the body may be affected by a deficiency in a food factor" (3).

The tissues generally recognized as affected by deficiency of vitamin C are the endothelium of the blood vessels and the teeth. It has been suggested that to prevent the development of subclinical symptoms, a daily intake of 330 to 540 International units of vitamin C is required for a 130 pound adult (4).

Thus it would appear that the optimum intake of vitamin C is at least twice the amount required to protect against scurvy.

Data recently published demonstrate that the vitamin C content of human milk is dependent upon the vitamin C content of the maternal diet (5).

Hence when the diet of the lactating mother is low in vitamin C, this factor is also deficient in the milk.

The League of Nations Technical Commission recommends an intake of over 500 International units per day during pregnancy and lactation (6).

The inclusion in the diet of liberal quantities of fruits and vegetables, prepared in such a manner as to retain a major portion of the original vitamin C content, may be relied upon to supply the need for this vitamin. The value of commercially canned foods as anti-scorbutics has been repeatedly demonstrated during the past decade (7).

More recently, the vitamin C content of many commercially canned fruits and vegetables has been determined and the results expressed in International units (8).

Consideration of two factors, namely, the quantitative requirement of the human for vitamin C, and the vitamin C potencies of commercially canned fruits and vegetables, emphasizes the value of these protective foods as sources of vitamin C.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) 1934-35. Am. Pub. Health Assn. Year Book. Page 71
(2) 1933. Chemistry of Food and Nutrition. H. C. Sherman. 4th Ed. Page 421 MacMillan, New York
(3) 1936. J. Am. Med. Assn. 106, 261
(4) 1934. Nature 134, 569
(5) 1936. J. Nutrition 11, 599
(6) 1936. League of Nations Report on Physiological Bases of Nutrition, League of Nations Publication Department, Geneva.
(7) a. 1925. Ind. Eng. Chem. 17, 69
b. 1928. Ibid. 20, 202
c. 1933. Ibid. 25, 682
(8) a. 1935. J. Nutrition 9, 667
b. 1936. Ibid. 11, 383
c. 1936. Ibid. 12, 405

This is the twenty-second in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

THE ABC METHOD IN HAY FEVER DIAGNOSIS

(Yes, it's just that simple)

FILL IN THIS COUPON

THE ARLINGTON CHEMICAL CO., Yonkers, N. Y., Biological Dept.
Enclosed find $1.00 for a complete set of pollen diagnostics for testing Hay Fever case. YJ-3

Date of onset of attack is_____

Date of termination of attack is_____

Signed_____ M.D.

Address_____

City_____ State_____

A YOU SEND US $1, with this COUPON.

B WE SEND YOU BY RETURN MAIL, specially made up for your locality and for your patient, a **POLLEN DIAGNOSTIC OUTFIT**

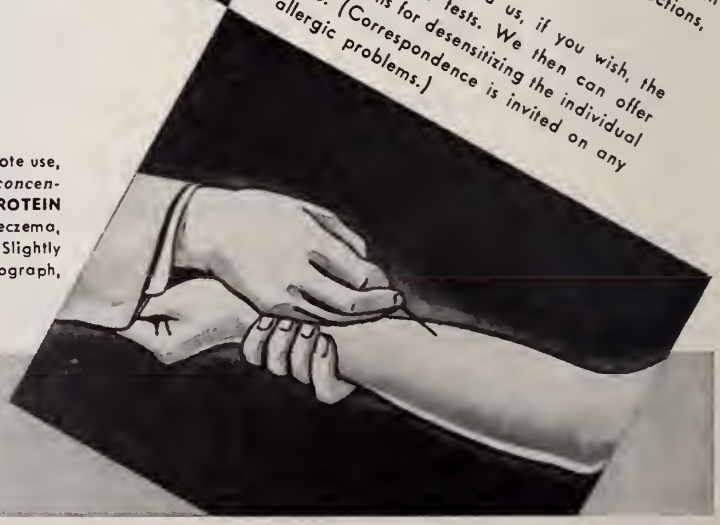


C YOU MAKE the tests and record them on the chart which, with directions, accompanies the set.

TREATMENT. Send us, if you wish, the results of your tests. We then can offer suggestions for desensitizing the individual case. (Correspondence is invited on any allergic problems.)

THE
Arlington
CHEMICAL COMPANY
Yonkers, N. Y.

POLLEN EXTRACTS (ARLCO), prepared for immediate use, can be promptly supplied; price lists of these, of *concentrated* pollen solutions, and of proteins, on request. **PROTEIN DIAGNOSTIC SETS** for use in asthma, infantile eczema, migraine, etc. 80 proteins, $25. 112 proteins, $35. Slightly higher in Canada. **ASK FOR** the new 36-page monograph, *The Principles of Allergy.*



Ease of Assimilation
and
Resistance to Fermentation
suggest

MELOTOSE No. 1

Ripe Banana (Dry)

...as the logical sugar to add to the infant's formula. The results obtained by its use in chronic intestinal indigestion fully justify its trial, not only in gastro-intestinal diseases but during any illness where fermentation is a special hazard.

Food Concentrates, Inc.

Care of

United Fruit Company

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Samples and Literature on Request



FOR HER BABY, RECOMMEND STRAINED FOODS BEARING—

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Every day, an increasing number of doctors give their active recommendation to Heinz Strained Foods for infants and soft diet cases.

One reason is that Heinz Strained Foods bear the Seal of Acceptance of the American Medical Association's Council on Foods. This means that they have been carefully investigated and officially accepted by your exacting profession.

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Recommend strained foods that have *both* the backing of your official body and the high esteem of experienced housewives and mothers throughout America. Suggest *Heinz!*

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It is made ready for use, simply by the addition of water.

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NEW YORK

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Complimentary samples on request

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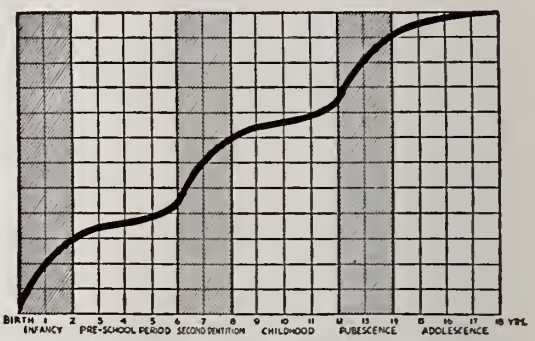
Alcohol	16 3/4 mins.
Calcreose Solution	160 mins.
Chloroform	1/10 min.
Wild Cherry Bark	20 grs.
Aromatics and Syrup	q. s.

THE MALTBIE CHEMICAL COMPANY

NEWARK, NEW JERSEY

How much should a child grow or gain from time to time?

That is more significant than mere weight and height measurements



CYCLES OF GROWTH FROM BIRTH TO MATURITY

The course of growth from birth to maturity is continuous but rhythmic. This span includes three cycles. The rapid growth in infancy is followed by the slow growth during the pre-school period; the rapid growth during the period of second dentition is followed by the slower growth during childhood; finally, the rapid growth during pubescence is followed by the slower growth during adolescence.

From Kugelmass' "Growing Superior Children", 1935. (Appleton-Century)

TO THE PARENT the mark on the wall and the reading on the scale reveal the child's growth. But *to the doctor* deviations from the periodic gains offer a sensitive index of dietary or disease disturbances.

The weight curve in infancy furnishes the most delicate index of progress. The birth weight doubles at five months and trebles at a year. Thereafter gains are slower; six pounds during the second year; five during the third; four during the fourth and fifth years. The trend of the first growth cycle is indicated in the chart.

THIS pattern of growth repeats itself during childhood and adolescence. Once the growth increments have been determined for a child, his assessment becomes individual and accurate.

When the child fails to gain in weight, high caloric feeding is simplified by reinforcing food with Karo Syrup. If the total caloric intake exceeds the output, the child will gain weight, provided the diet is adequate and chronic disturbances corrected.

Every Article of Diet can be Enriched with Calories

Karo provides 60 calories per tablespoon. It is relished added to milk, fruit and fruit juices, vegetables, vegetable waters, cereals, breads and desserts. Karo consists of dextrins, maltose and dextrose (with a small percentage of sucrose added for flavor).

For further information, write
CORN PRODUCTS SALES COMPANY
Dept. SJ-3—17 Battery Place, New York, N. Y.



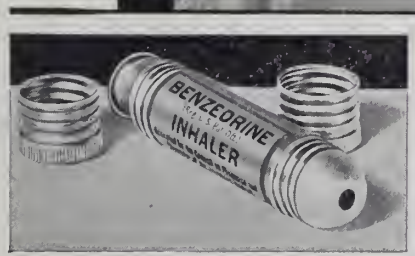
★ **Infant feeding practice is primarily the concern of the physician, therefore, Karo for infant feeding is advertised to the Medical Profession exclusively.**

For Children's Colds

In prescribing 'Benzedrine Inhaler' for children's head colds, you are providing a first aid remedy which may prove of constant service.

At the first sign of a cold the child is instructed to use the inhaler. Since benzyl methyl carbinamine is volatile, it penetrates to areas not readily accessible to liquid inhalants, and there is no oil to be aspirated and become a potential source of later trouble by accumulating in the lungs. (Graef—Am. J. of Path., Vol. xi: No. 5, Sept. 1935.)

For the adult members of the family, 'Benzedrine Inhaler' is equally useful.



Each tube is packed with benzyl methyl carbinamine, .325 gm.; oil of lavender, .097 gm.; menthol, .032 gm.

'Benzedrine' is the trade mark for S. K. F.'s nasal inhaler and for their brand of the substance whose descriptive name is benzyl methyl carbinamine.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

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A VOLATILE VASOCONSTRICTOR

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BILHUBER-KNOLL CORP.



FOR the failing heart of middle life give Theocalcin, 2 or 3 tablets, t.i.d. After relief is obtained, the comfort of the patient may be continued with smaller doses. Strengthens heart action, diminishes dyspnoea and reduces edema

THEOCALCIN (theobromine-calcium salicylate) *Council Accepted*

Available in 7½ grain tablets and as a powder . . .

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G. W. CARNRICK CO.

Dependable Gland Products

2-24 Mt. Pleasant Ave. **Newark, New Jersey**

Old Way...

CURING RICKETS in the CLEFT of an ASH TREE

FOR many centuries,—and apparently down to the present time, even in this country—ricketic children have been passed through a cleft ash tree to cure them of their rickets, and thenceforth a sympathetic relationship was supposed to exist between them and the tree.

Frazer* states that the ordinary mode of effecting the cure is to split a young ash sapling longitudinally for a few feet and pass the child, naked, either three times or three times three through the fissure at sunrise. In the West of England, it is said the passage must be "against the sun." As soon as the ceremony is performed, the tree is bound tightly up and the fissure plastered over with mud or clay. The belief is that just as the cleft in the tree will be healed, so the child's body will be healed, but that if the rift in the tree remains open, the deformity in the child will remain, too, and if the tree were to die, the death of the child would surely follow.

*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923



It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

New Way...

Preventing and Curing Rickets *with* OLEUM PERCOMORPHUM

NOWADAYS, the physician has at his command, Mead's Oleum Percomorphum, a natural vitamin D product which actually prevents and cures rickets, when given in proper dosage.

Like other specifics for other diseases, larger dosage may be required for extreme cases. It is safe to say that when used in the indicated dosage, Mead's Oleum Percomorphum is a specific in almost all cases of rickets, regardless of degree and duration. Mead's Oleum Percomorphum because of its high vitamins A and D content is also useful in deficiency conditions such as tetany, osteomalacia and xerophthalmia.

Mead's Oleum Percomorphum is not advertised to the public and is now obtainable at drug stores at a new economical price in 10 c.c. and 50 c.c. bottles and 10-drop capsules.

MEAD JOHNSON & COMPANY, Evansville, Indiana, U. S. A.

Please enclose professional card when requesting samples of Mead Johnson products to cooperate in preventing their reaching unauthorized persons



The control of syphilis today is one of the major problems of the medical profession. The necessity for concerted action in bringing syphilitic individuals under treatment is evident from the estimate that from 5 to 10 per cent of the population is infected, and that there are more than 500,000 new infections annually.

The infectiousness of early syphilis may be controlled by prompt and adequate treatment with neoarsphenamine and bismuth.

The administration of neoarsphenamine and the preparation of solutions require care, but these procedures are readily acquired. Information regarding them may be obtained by returning the attached coupon.

Please send me instructions on the technique of preparing solutions and administering injections of

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Name..... M.D.

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City..... State.....

MERCK & CO. INC. *Manufacturing Chemists* **RAHWAY, N. J.**



PUBLICITY *plus* POTENT PRODUCTS

THE NATIONWIDE campaign to control venereal disease is receiving valuable publicity from many sources. The final results of the campaign, however, will depend upon the effectiveness of the products used and the proper supervision of all cases.

It is generally agreed that efficient treatment requires the administration of an arsenical and a heavy metal, alternately and continuously, for a period of from twelve to eighteen months. For this purpose Squibb has available two outstanding preparations—Neoarsphenamine and Iodobismitol with Saligenin.

Neoarsphenamine Squibb is designed to produce maximum therapeutic results. It is noted for its high stability, chemical uniformity, rapid solubility, brilliantly clear solution, low toxicity and high spirocheticidal power. Equally effective for the conditions in which their use is indicated are Arsphenamine Squibb and Sulpharsphenamine Squibb.

Iodobismitol with Saligenin provides all the systemic effects of bismuth in the treatment of syphilis. It presents bismuth in anionic (electro-negative) form. It is slowly and completely absorbed and slowly excreted, thus providing a relatively prolonged bismuth effect. Repeated injections are well tolerated in both early and late syphilis.

Iodobismitol with Saligenin is a propylene glycol solution containing 6 per cent sodium iodobismuthite, 12 per cent sodium iodide and 4 per cent saligenin (a local anesthetic).

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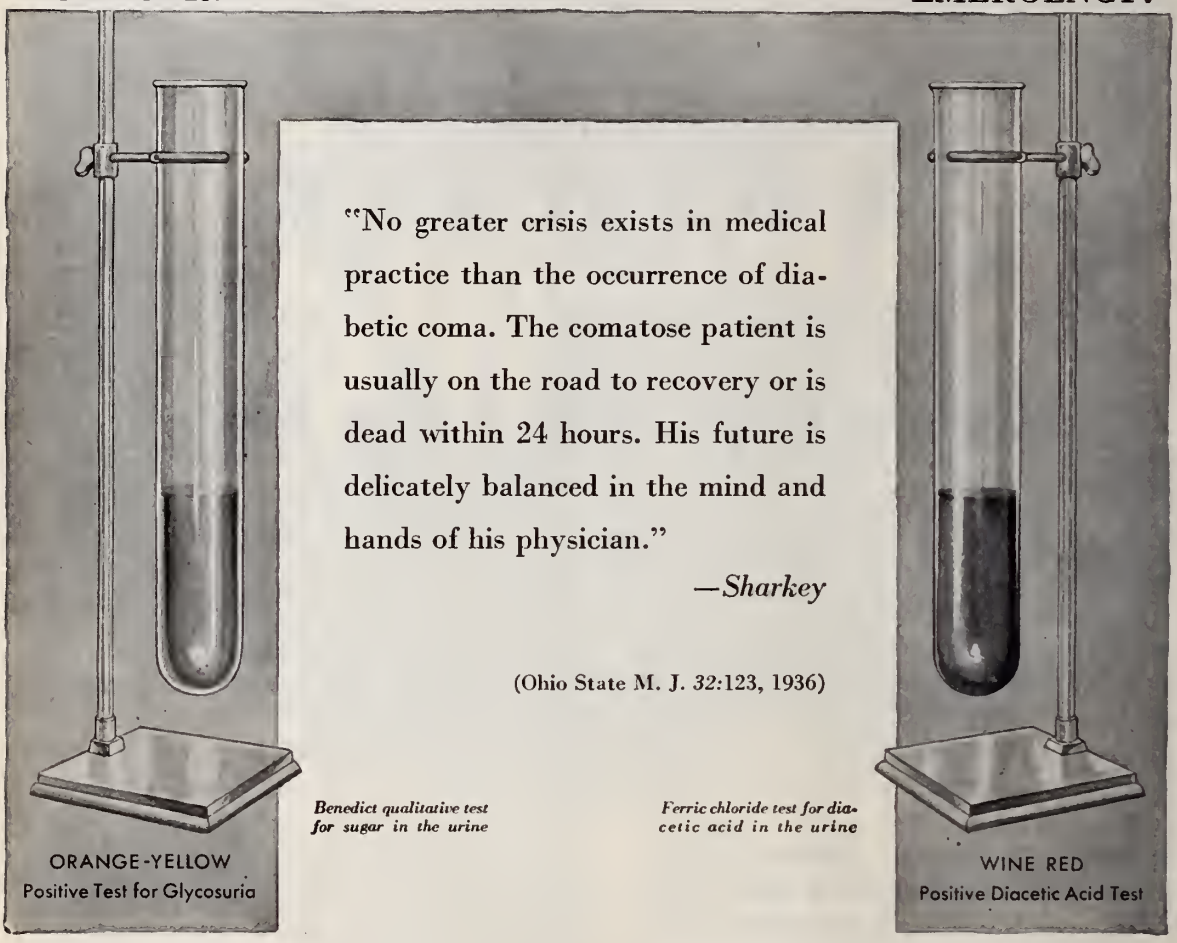
For literature address the Professional Service Department, 745 Fifth Avenue, New York City.

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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

Diabetic Acidosis

DANGER! **EMERGENCY!**



Early Portents	Later	Then
Polyuria.....	Loss of strength.....	Nausea and vomiting
Polydipsia.....	Loss of weight.....	Desiccating of tissues
Polyphagia.....	Loss of appetite.....	Unconsciousness

Important Factors in Treatment

1. INSULIN early and in repeated doses. **2.** FLUIDS to combat dehydration.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly

Under the
Direction of the
Committee on Publication



Editor of
The Journal
Frank Overton, M.D., Dr. P.H.

Editorial and Executive Offices of the Society
137 East State Street, Trenton, N. J., Tel. 9330
Executive Officer—LeRoy A. Wilkes, M.D.
Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. XXXIV, No. 3 March, 1937 Subscription, $3.00 per Year
Single Copies, 30 Cents

EDITORIALS

Friendliness at the Annual Meeting

Preparations for the Annual Meeting of The Medical Society of New Jersey, to be held on April 27, 28, and 29, in Haddon Hall, Atlantic City, are more complete and further advanced than ever before. The officers and committees have given their time and their best thought to making plans and arrangements which will appeal to every member. Some members will be attracted by one feature, and others by another part of the program; but a feature which will appeal to all is the friendly contact of doctor with doctor.

The Medical Society of New Jersey is a great fraternity of physicians of widely varying temperaments and characteristics; but one feature which every doctor expects to find is *friendliness,*—and no one will be able to say that this attractive virtue will be lacking.

There are members who emanate friendliness,—who will speak to everybody, and draw out those whose inclination is to sit on the side lines waiting for recognition. These retiring members appreciate attention that is given to them. The most common excuse that members give for not attending the annual meetings is that no one takes notice of them; and vice versa, the greatest appeal for a member to become a regular attendant is that he will renew a few friendships which he acquired at the first meeting that he attended.

It is a common saying that any one will make friends if he desires them. This is only a half truth. If a person goes away with a feeling of loneliness, the fault is not his so much as the neglect of the regular attendants to approach him and engage him in sympathetic conversation.

A common plan for promoting a friendly feeling is to appoint a reception committee to greet the members as they arrive. This is an excellent idea; but a much more effective plan is that the members of such a committee be continuously on the look-out for the doctor who seems to be alone and sits by himself. This type of retiring member is more numerous than is generally realized; and the members of the reception committee will find abundant opportunities to make him feel at ease.

The best reception committee is that which is self-appointed,—each one unobstrusively seeking the doctor who seems to prefer to sit alone, and to have no pals. This member will invariably respond to friendly greetings, and will go home with a strong desire to attend the next convention with a keen expectation of meeting the new friends which he has found.

The Handbook of Preventive Procedures

The Handbook of Procedures in Preventive Medicine is issued as a supplement to this Journal. Its preparation was proposed by Dr. Stanley Nichols, Chairman of the Committee on Public Health. It was at first thought that the field could be covered in twenty pages; but after the chapters had been written in outline form, the demand for the insertion of additional subjects was ten-fold that for the elimination of any topic. The Handbook has therefore grown spontaneously to over sixty pages.

It is strange that no handbook or manual on preventive medicine has previously been written from the point of view of the Family Doctor. When public health workers are asked to name procedures to be carried out by the Family Doctor in any branch of service, they begin by telling what the county society should do. It would seem that the Family Doctor has been neglected as a public health factor; and probably he himself does not realize how essential he is in a comprehensive system of preventive medicine, for no one has told him.

The Handbook is designed for reference, and as an index which will enable the physician to recall the essential items in any preventive problem with which he has to deal.

Keep the Handbook on your office table, and read it as occasion or opportunity arises.

The Executive Body of the State Society

The Medical Society of New Jersey has always been democratic in its organization and government. During fifty years after its founding in 1766, a few officers managed the affairs of the Society, with now and then a committee appointed for a special purpose. Only a dozen or fifteen members attended a meeting, and these functioned as a Committee of the Whole.

BOARD OF MANAGERS, 1816

The first provision for an executive committee was contained in an Act of the Legislature passed February 16, 1816, incorporating The Medical Society of New Jersey, and authorizing the election of certain officers, including fifteen members of a *Board of Managers*. The Board met during the Annual Meeting in May, 1816, and drafted a set of by-laws for the Society, appointed a Board of Censors, and adopted a seal of the Society.

STANDING COMMITTEE, 1820

In May, 1817, the Board of Managers assumed the prerogative of electing the officers of the State Society, but apparently the members did not like to be "managed", for on May 9, 1820, the Society adopted new by-laws which did not mention the Board of Managers, but provided a Standing Committee, whose functions were prescribed as follows:

1. Investigate and report annually the state of health of the citizens of New Jersey.
2. Report on irregularities of action by county societies.
3. Decide questions of ethics arising in the county societies.
4. Act as guardians of the State Society, and suggest measures for the best interests of its members.
5. Edit and publish papers read before the Society.

BOARD OF TRUSTEES, 1903

The Standing Committee functioned with great activity and efficiency for eighty-three years, until the first Constitution of the Society was adopted in 1903, and provided that the duties of the committee should be performed by a Board of Trustees, to be composed of the President, the First Vice-President, the Recording Secretary, and the Fellows.

The Constitution and By-Laws of 1903 also provided that many items of the Society's internal activities that had been conducted by the former Standing Committee should be assigned to six Standing Committees, each of which is as busy as the whole committee was a half a century ago.

WELFARE COMMITTEE, 1921

A unique landmark of progress was the creation of the Welfare Committee in 1921, in order to unify all the activities which are directly connected with the private practice of medicine. This committee has about twenty sub-committees covering every field of medical practice; but the members of all committees assemble frequently, and discuss the work of each component group, thereby securing unity of purpose and harmony of execution.

The system of organization of The Medical Society of New Jersey has grown by developing each step upon a foundation that had already been tested and tried in actual experience. New social conditions are calling for adjustments in medical organization and practice; and The Medical Society of New Jersey is demonstrating its ability to adjust itself to its newer relations, just as it has done in the past.

The landmarks of the development of the organization of The Medical Society of New Jersey may be summarized as follows:

1766-1816.—The Society functioned as a committee of the whole, with now and then a special committee for an emergency, such as that of 1772 when it secured the enactment of the first medical practice act of the State.

1816.—A Board of Managers was established by the Law which incorporated The Medical Society of New Jersey.

1820.—A Standing Committee was formed which combined the business duties of the Managers with new ones in public health.

1903.—The adoption of the first Constitution of the State Society, with its provisions for a Board of Trustees in place of the Standing Committee.

1921.—The establishment of the Welfare Committee.

County Society Organization

The Medical Society of New Jersey has developed an organization which functions efficiently because:

1. Each activity has been developed to meet a need that is universal throughout the State.
2. When a need has become evident, a committee has been appointed to propose a method of solving the problem.
3. A similar committee has been formed in each county society to bring the solution to the attention of every member.

The central state committee is the *Welfare Committee,* which is composed of about twenty subordinate committees whose members are privileged to attend the Welfare Committee, sit at its meetings, and thereby learn what the other committees are doing.

The system represents a cross-section of the physicians throughout the State, and covers practically every phase of the private practice of medicine.

Early last Fall, the members of the Welfare Committee suggested that every county society pattern its system of committees after that of the State Society. This suggestion has been considered by many of the societies, and adopted by some of the largest.

Somerset County, with a membership of sixty, has also adopted the system of the State Society, and has assigned to each the supervision of the same activities that are carried on by a similar committee of the State Society. (See this Journal, page 214.)

The officers have made a study of the membership and have assigned each member to those activities in which he is specially interested or for which he has a special talent.

A feature of the assignment of the personnel is that it includes every member of the Society. No one has been singled out for "Honor", but each member has been assigned to a specific task whose performance brings honor to himself as well as the county society.

There is a committee available in Somerset County ready to deal with any situation which may arise. The members of the Medical Society of Somerset County are to be congratulated for their wisdom and activity.

Preventive Medicine and Public Health

A confusion of the meaning of common words and simple expressions is a hindrance to progress in the practice of medicine. An example of this confusion is the use of the words *"Preventive Medicine"* to mean the same as *"Public Health"*.

The practice of public health proper began in the decade of the nineties with the development of the science of bacteriology and its application to water supplies, sewage disposal, and milk routes, in which the element of *compulsion* was necessarily dominant, and still is.

The people were entirely willing that the new principles of public health should be applied in a *public way,* so long as the *individual* citizen was not put to inconvenience with his own wells, cow-stables, and outhouses. This feeling was reflected in the attitude of practicing physicians, for they did not feel that they should compel their private patients to do anything which they did not want to do.

In those early days the term "Public Health" was not popular with practicing physicians who received neither pay nor thanks for their pioneer services in preventive medicine.

THE RISE OF PREVENTIVE MEDICINE

The second step in public health progress was the development of the science of *immunology,* which was the application of public health measures to individuals. Diphtheria prevention was the beginning of the practice of "Preventive medicine" as it is known today. Attempts to carry over the older public health idea of *compulsion* into the preventive field met with opposition from both the people and the physicians. In those days it was difficult to induce well-qualified family doctors to accept the office of local health officer; and they were quite willing that the office should be given to young physicians who had no practice to lose, and on the contrary were eager for the opportunity to enhance their prestige by accepting any public office that came their way. However, the older physicians gradually adopted the practice of *preventive medicine* among their private patients who voluntarily accepted it, although they were unwilling to enter the field of *public health* as it was then practiced.

RISE OF VOLUNTARY HEALTH ASSOCIATIONS

Before the people would seek or accept the benefits of preventive medicine, it was necessary to inform them of the benefits of its procedures. Hence there arose voluntary health associations, and the establishment of public clinics for bringing people together to receive immunizations at the hands of volunteer physicians. It is difficult to see how the cause of preventive medicine could have been promoted in any other way.

EARLY DIAGNOSIS

The third step in the application of the principles of public health was taken by practicing physicians themselves in the development of the science of "Pathology", which pushed back the time of diagnosing diseases to the date of their *onset.* Early diagnosis and treatment therefore became a public health measure of the first importance. The older physicians often covered their ignorance by their diagnosis of "threatened" diphtheria or typhoid; and when the mild cases recovered, these doctors often got the credit for "preventing" something which already existed. Yet the term "Public Health" continued to be applied to preventive measures which were entirely within the scope of modern private practice.

It is difficult to see how either the medical profession or the people can be brought to make an accurate distinction in their use of the terms "Public Health" and "Preventive Medicine" in their contrasting meanings; but happily the distinction is being made more and more widely; and physicians are increasingly willing to practice "Preventive Medicine" provided the old implication *compulsion* is eliminated from it.

Throughout the "Handbook of Preventive Procedures", which is issued as a supplement to this number of The Journal, the term "Preventive Medicine" is used in preference to "Public Health", to describe the preventive measures which the Family Doctor applies to his private patients.

The Exhibit of Medical History

The Medical Society of New Jersey is pre-eminent for its achievements throughout the one hundred and seventy-one years of its existence. For the compilation of the records of the Society and its individual members, and their publication, the Society is indebted to Dr. Stephen Wickes, who made that work his studied avocation throughout the decade of the seventies.

The time has now come for an organized effort to continue the work which he began, and to bring the record down through the sixty years since Dr. Wickes completed his monumental service. Many of the mementoes and records with which he was familiar have disappeared, but many are still available to those who will search for them and make a record of their whereabouts. To do this work is the peculiar opportunity of the members of the Auxiliary.

Last year the Auxiliary initiated a historical exhibit whose outstanding importance will become more and more evident as the scope of the exhibit is expanded. An inevitable difficulty in securing historical exhibits is that of assuring their safety while they are on exhibition and during their transit to and from the Annual Meeting; but it is entirely possible to make a record of original materials and the places where they may be seen and studied. This is a work for which the members of the Auxiliary are well fitted.

The Auxiliary can adopt no more important project than that of promoting a knowledge of the medical history of New Jersey.

Medical Service for All

Henry Ford has done more than any other man to provide automobile transportation for the people in America. This was made possible only because he kept his mind fixed first on providing satisfactory and economical service. Mr. Ford has shown us that a market can be found or created for an ever-increasing production of such service.

Medical service also meets an ever-present need that is recognized by the public generally. The area of distribution of this service also depends upon the satisfaction given to those who are in need thereof, and the ability of the public to pay for it.

We physicians cannot allow our services to become less efficient nor ever to remain stationary. Our services must constantly improve and cost relatively less.

How can this be done? One way is to cut waste, improve our efficiency and organize our efforts. We must have two organizations—one to *produce* high-class professional services; and another to *distribute* these services economically. We already have the first type of organization; and we are now engaged in seeing whether we ourselves will provide the second type, or whether the government will do this before we *demonstrate* our own willingness and ability to do it.

Financial income will be increased only by widespread distribution of our services to the public at a cost which they can pay. This service, in a final analysis, will be provided by those who can give the best service at the lowest cost. Some people think that the government can best meet this demand. The medical profession claims that its members can do it better. The public issues the challenge and will favor the one which proves its claims through demonstration and service. L. A. W.

Growing Young

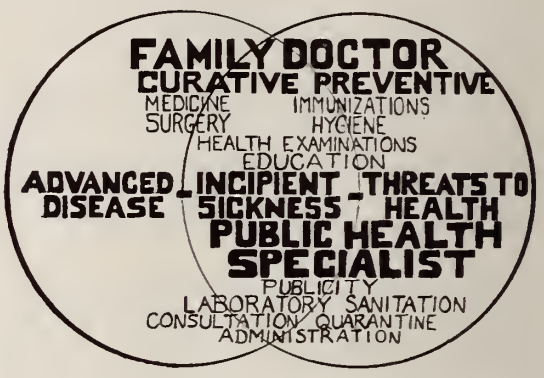
Old age is a state of mind rather than of the body. To retain the bright outlook of youth after the age of seventy is an achievement worth the effort. Every doctor needs an avocation which compels him to seek diversion. The Woman's Auxiliary is doing an excellent piece of work in preventive medicine among physicians by encouraging them to exhibit specimens of their diverting handiwork at the Annual Meeting.

Modern Preventive Medicine

Preventive medicine has always existed in the practice of the healing art; but the practice of public health in a scientific way began with the application of bacteriology by governments to sewage disposal and water supplies. These measures protected every individual person without his knowledge, often against his will and under *compulsion;* and hence they were considered to be incompatible with the spirit of private practice in which the relation of physician to patient is voluntary and spontaneous. The people opposed them because they could see no sense in the restrictions imposed on themselves when no disease was evident; and Family Doctors were lukewarm in their application of preventive measures to unwilling patients.

During the decade of the nineties, the medical profession was sharply divided into two groups,—a minority of physicians employed as health officers, and a majority who did private practice and were glad to let the "Health" doctors attend to those phases of medical service which were impersonal and public in their nature.

The circles of influence of the two groups of doctors were almost entirely separated. The Family Doctor complained when their patients were visited by health officers; and the public health doctors called the family doctors reactionary and unprogressive.



The field of preventive medicine now overlaps that of public health proper; and physicians and organizations engaged in each kind of practice are recognizing the peculiar scope of activities which belong to each group, as are indicated in the accompanying diagram.

Plans and Accomplishments

This has been a busy month for the officers and committeemen of The Medical Society of New Jersey. The work of the year is largely completed; but there still remains the great work of striking a balance sheet between the work that was planned with that which has been completed, as the officers and committeemen will do in their annual reports to the House of Delegates. These reports will also contain suggestions for continuing their work during the coming year.

The Medical Society of New Jersey is a continuing organization whose work will never be completed. Past success is a great incentive to more extensive action to come. An annual report is not complete unless it contains definite suggestions on which the Reference Committees and the House of Delegates may sit in judgment.

Many of the reports this year are already prepared and have been submitted to the Trustees or the Welfare Committee for approval. This plan will result in definiteness of plans and harmony of their execution, since the work of all the separate units will be coördinated into a well-rounded plan of action.

The members of the Reference Committees of the House of Delegates have an onerous task to perform at the Annual Meeting. Their names will be published in the April Journal, so that any member of the State Society may know to whom he may go in order to receive a courteous hearing. The place for debate on the annual reports is in the rooms which will be assigned to the Reference Committees.

ORIGINAL ARTICLES

SEROLOGICAL DIFFERENCES IN HUMAN BLOOD, AND THEIR PRACTICAL APPLICATION

By Philip Levine, M.D., Newark, N. J.
From the Department of Laboratories, Beth Israel Hospital, Newark, N. J.

In the last decade or so, considerable knowledge has accumulated as a result of researches along the line of blood groups and serological differences of human blood in general. In the first place, a correct theory of the heredity of the blood groups was contributed by the mathematician, Bernstein, only as recently as 1924-1925. As a result of this finding, a firmer foundation was established for the practical application of these tests for the exclusion of paternity in bastardy cases; and European courts, in contrast to American courts, have already acquired considerable experience in this field.

Secondly, new hereditary agglutinable properties of human blood, aside from the four blood groups, were recently described by Landsteiner and the writer, who furnished a basis for the use in paternity cases of some of these blood factors, namely the immune agglutinable properties M and N. Thus, at the present stage of our knowledge, an exclusion of paternity can be made in 33 per cent of all instances in which false accusations are made.

These and other contributions prove the existence of numerous individual differences in human blood, and presumably, tissue cells; and reasoning by analogy such differences are significant in connection with the outcome of transplantation of tissues in men. The entire subject was made prominent by the award, in 1930, of the Nobel prize in medicine to Dr. Karl Landsteiner for his discovery, thirty years previously, of the four blood groups, his correct description of the theory, and their application to blood transfusions in man. It is the object in this communication to discuss some of the more recent findings; and to include, briefly, the question of selection of donors for transfusions, and to consider, in somewhat greater detail, the medico-legal applications.

THE FOUR BLOOD GROUPS

Although the four blood groups and their demonstration are common knowledge, the scheme is here reproduced in order to emphasize several points.

TABLE 1

Serum of Group	Agglutinins in Serum	Red Blood Cells of Group O	A	B	AB
O	*a* and *b*	—	+	+	+
A	*b*	—	—	+	+
B	*a*	—	+	—	+
AB	—	—	—	—	—

\+ signifies agglutination.
— signifies absence of agglutination.

In the first place, it is recommended that the terminology by numerals be gradually abandoned and replaced by the so-called Landsteiner or International nomenclature; i. e., O, A, B, and AB. Aside from the fact that two distinct systems of numberings are confusing (I of Moss is the IV of Jansky), the use of the letters offers the distinct advantage in that this terminology is based on the theory of two independent agglutinable properties (agglutinogens) of the red cells, A and B, determining groups A and B respectively; their absence in group O, and their simultaneous presence in group AB. This nomenclature has been officially recognized by the National Research Council, the American Association of Immunologists, and by the Health Committee of the League of Nations.

As is evident from the agglutination reactions of red blood cells when tested with potent stock sera of group A (isoagglutinin *b* or anti-B) and group B (isoagglutinin *a* or anti-A), the group O cells and group AB cells are readily selected by virtue of their respective properties of inagglutinability (group O), and agglutinability by either of the two sera (group AB). In other words, these two sorts of bloods can readily be selected, even without the use

of typing sera, in suitable experiments in which the sera of a suitable number of individuals are cross-tested with the same number of cells. With known stock grouping sera, the bloods A and B can be readily differentiated, since they are cross-specific. In the absence of typing sera, if one resorts to the cross test referred to above, bloods A and B can be differentiated from each other since in the white population the incidence of the one, group A, is far greater than that of group B (40 per cent and 10 per cent respectively). More directly, the two groups can be distinguished since certain rabbit anti-sera which contain hemolysins for sheep blood, at the same time have the remarkable property of agglutinating only bloods containing the factor A. These antibodies may be produced by injecting rabbits with substances of such varied biologic origin as suspension of tissues from guinea pigs or horses, bacilli such as paratyphosus B, paradysenteriae Gettings, B lepisepticum, and also, as is to be expected, sheep blood.

Antibodies for A and B of weak or moderate activity are widely distributed in the normal sera of numerous animals. Potent antibodies may be produced by injecting rabbits with bloods A (or B); but such sera, as well as normal animal sera, frequently contain also the species-specific antibody which acts on all human blood; consequently, the sera must previously be absorbed by contact with blood lacking in A (or B) before specific diagnostic reagents are available.

SOURCE OF ERROR IN BLOOD GROUPING

While the performance of the tests for the determination of the blood group of any red cells is a very simple matter, there are a few phenomena that must be recognized since they are sources of error, particularly for the inexperienced. These are pseudoagglutination (rouleaux-formation), and the effects attributable to cold agglutinins, autoagglutinins, and atypical agglutinins active at room temperature.

Without going into too great detail, the confusing effects of pseudoagglutination may be circumvented by diluting the stock typing sera 1:2 or 1:3. Preferably, stock sera should be taken only from healthy individuals, and not from patients suffering from infectious diseases and other conditions, such as pregnancy, which are characterized by a rapid sedimentation. Indeed, the same substances in the serum which cause the rapid sedimentation of the red cells are also responsible for the rouleaux-formation which can so closely simulate isoagglutination.

The effects of auto- and cold-agglutination are very seldom a source of serious error if the tests are not carried out at low temperature (4° C.). Only very rarely are they active at room temperature; and exceptionally it may be difficult to obtain a uniform (non-agglutining) cell suspension unless the blood is kept at 37°.

Atypical agglutinins are characterized by their capacity to agglutinate cells within the same group under the usual condition of testing at room temperature; consequently, they are a more serious source of error. Such exceptional agglutinins are present in about three per cent of normal sera, according to investigations of Landsteiner and Levine. These reactions, which in certain instances may be quite intense, are due to specific antigen-antibody effects. In the great majority of the cases, the reactions disappear when the test tubes are further incubated at 37°. It is, therefore, readily conceivable why they should play no significant rôle in post-transfusion reactions. Even in those instances where these atypical reactions persist at 37°, they are far less intense and, curiously enough, no ill effects have been observed in the few published instances in which patients having such atypical agglutinins were transfused with sensitive blood of the same group.

From a practical standpoint, it is important to bear in mind that the difficulties incidental to these interesting phenomena are limited to the atypical agglutinins in the serum only, and not to the corresponding cell, the group of which can be readily determined, provided that the stock potent typing sera are free from these agglutinins. (This selection can readily be made by demonstrating the absence of any agglutination when the sera are tested at room temperature on cells of their corresponding group, as well as on cells of group O.) Once

a prospective donor is selected of the same group as the patient, a suitable direct matching can exclude those rare combinations of incompatibility due to these agglutinins, namely, atypical agglutinins in the patient's serum, and sensitive (agglutinating) cells of prospective donor.

These reactions are of theoretical interest, since such agglutinins serve as reagents for the detection of additional agglutinable factors which assume considerable importance in view of their distinct heredity and varying distribution in different races. In this manner, Landsteiner and myself provided proof for the existence of the qualitatively different subgroups, A^1 and A^2 of groups A and AB; with the aid of another atypical agglutinin we demonstrated the agglutinable property P characterized by greater incidence in the colored race and also several other less well-defined blood properties.*

Before dismissing this question, it may be stated that the existence of these agglutinins does not in the least interfere with the scheme of the four blood groups; they may be viewed as independent phenomena superimposed on the blood groups; and as already mentioned, they provide support for the view, later to be discussed, that the red cells of each individual is different from that of every other individual.

THE BLOOD GROUPS AND TRANSFUSION

With regard to the use of preliminary blood tests prior to blood transfusion, the experience acquired during the Great War offered for the first time a dramatic demonstration on a very large scale of the feasibility and usefulness of this procedure, which was at one time legally forbidden. It is very curious that in the fourteen years' interval following the discovery of the blood groups, transfusions did not rise to the dignity of a recognized routine therapeutic measure. In the American literature, the first reference to blood groups and transfusion is to be found in papers by Hektoen in 1907; and the use of the compatibility test, prior to transfusion, was mentioned for the first time by Ottenberg a year later. The latter worker pointed out that, since the incompatibility in blood transfusion consists in the injection of agglutinable donor cells, it is safe to use individuals of group O as donors for patients in any group. Although in such combinations isoagglutinins are injected which may be active against the patient's cells, these agglutinins are, as a rule, sufficiently diluted in the much larger volume of the patient's blood. Practical experience has demonstrated the use of the universal donor as a safe procedure except for those very rare instances in which the isoagglutinins in the donor's serum are so very potent that they are not sufficiently diluted in the patient's circulation, and especially so in the presence of two other factors frequently found in patients, namely anemia and a low blood volume. Under such conditions, violent and even fatal outcomes are possible and several such cases have indeed been reported. Although all workers are agreed that it is preferable to use a donor of the same group as the patient, it seems to me that for impecunious patients, when a donor of the same group cannot be found among his friends and family, it is a safe procedure to select among the latter an individual of group O, provided that the direct test suggested by Coca be made to detect abnormally active agglutinins. If no agglutination occurs in a mixture of five parts defibrinated patient's whole blood and one part defibrinated donor's whole blood, that O donor may safely be used. In a suitably organized donor bureau, quantitative studies should be made of group O donors, and in this manner lists of individuals are available as safe donors for cases of such urgency that the delay incidental to the compatibility test is dangerous.

The properties A and B are not confined to blood cells, but have been demonstrated also in spermatozoa, and to varying degrees, in cells of certain organs such as pancreas, liver, kidney, and other tissues. The isoagglutinable substance in tissues must be demonstrated indirectly; i. e., by the capacity of blood-free tissue suspensions to specifically bind, and therefore inhibit the reaction of the particular isoagglutinin with its homologous blood cells. With this same method it is possible to demonstrate the presence in soluble form of the substances

* For further information on this subject see Jour. Immunology, 17, I, 1929, and 20, 179, 1931.

A and B in seminal fluid, saliva, tears, and urine. This remarkable fact is available for practical application in forensic medicine, for instance, in cases of rape, and blackmail (detection of the substance in dried saliva on envelopes, etc.). Curiously enough, not all individuals of group A eliminate the A substance in the saliva, and the capacity to eliminate is inherited in a simple mendelian manner (Schiff). Presumably those individuals failing to eliminate the substance, secrete an enzyme which destroys it.

The specific reaction of soluble body fluids and isoagglutinins is of great interest to the biochemist, who thus has a readily available source of material to investigate the chemical nature of substances A and B. Although specific reactions can be obtained with alcoholic extracts of red blood cells, it is quite difficult to obtain sufficiently large yields of active substance from this source.

THE NEW AGGLUTINABLE FACTORS (M, N, P AND OTHERS)

The first observations on the demonstration of the blood factors M and N were made with numerous stock rabbit sera immunized for human blood, with the hope that special antibodies for factors other than A and B could be demonstrated in at least some of the sera. Absorption tests with each of several sera were made with a few bloods, and each of the resulting fluids were tested with a number of different cells. Under such conditions, three independent coincidences were required for the first demonstration in human blood of differences other than A and B. In the first place, it was necessary to find a serum which had a particular antibody; secondly, the blood used for the absorption must be lacking in the corresponding factor; finally, at least one of the bloods used in testing the quality of the absorbed serum must differ from the absorbing blood in possessing the corresponding blood factor. Subsequently, it became possible to inject rabbits with known bloods containing the respective properties and to continue injections until preliminary absorption tests revealed the presence of potent antibodies.

On testing numerous blood cells with suitably prepared specific reagents, three sorts of bloods were found,—one containing both factors, hence type M+N+ (or MN); another containing only factor M, i. e., M+N— (or M); and the third containing only the property N, i. e., M—N+ (or N). Although thousands of bloods were tested by numerous workers throughout the world, not one blood was found which was lacking in both properties. Roughly, the distribution of the types MN, M and N in the white race is 50, 20, 30 per cent, respectively. The M and N factors are independent of the four blood groups and the sub-groups of A and AB, so that the eighteen different sorts of blood can thus be recognized. In contrast to A and B, M and N could not be demonstrated in normal tissue cells, or in body fluids.

These properties play no rôle in the selection of donors for transfusion, since isoantibodies specific for M and N are not, as a rule, to be found in normal human serum. With the aid of these factors, it was possible to detect donors' blood cells in the circulation of the patient in those compatible instances in which, for instance, the donor is M and the recipient is N. By examining the blood of such a recipient from time to time, Landsteiner, Levine, and Janes were able to demonstrate donors' blood still present one hundred days after the transfusion. This observation confirms the results of Ashby on the length of life of the transfused corpuscle obtained by another method, namely counts of unagglutinated cells in mixtures with anti-A agglutinins of the post-transfusion specimen of A individuals receiving blood of group O.

The third property, P, was first demonstrated by means of an agglutinin in suitably absorbed normal animal sera (horse, beef, rabbit), the specificity of which corresponded with some of the atypical agglutinins of normal human sera. This property, which is less well-defined than M or N, may be demonstrated, also, by means of immune rabbit sera (prepared by injecting the animal with sensitive blood known to contain the property) suitably absorbed with bloods lacking in this factor. When numerous bloods of any group, and inde-

pendent of M and N, are tested with the three sorts of reagents,—normal animal sera, immune animal sera, and the atypical agglutinin in human sera,—the reactions of most bloods are found to correspond, but certain exceptions are found. This factor, thus, increases the number of individual different blood types from 18 to 36. Strong reactions for P are found to occur with considerably greater frequency in the colored race.

Landsteiner, Levine, and Janes described another agglutinin in the serum of an individual transfused several times, which differentiated bloods independently from the other known blood factors. Thus, the number of different types are now 72. Taking into consideration another characteristically different atypical agglutinin described by Ottenberg and Johnson, 144 serologically characteristically different sorts of human blood can be identified. To illustrate this striking individuality, table 2, from one of Landsteiner and Levine's publications, is given, which shows that the nine individuals,—five in group O, and four in group A,—working in the laboratory at the Rockefeller Institute, are individually different when tested with antibodies for M and N, the subgroups, the factor P, and the antibody of Ottenberg and Johnson.

More recent investigations by Schiff and Furuhata indicate the existence of additional blood factors, but comprehensive studies are required to establish whether or not these factors are different from each other.

Taking into account only plus and minus variations, only twenty different blood factors are required to produce 1,024,576 individually characteristic combinations; i. e., 2^{20}. The figure becomes still greater if one considers also the quantitative variations which undoubtedly exist for the factor P and others. A similar striking individuality was demonstrated, also, for blood cells of several species of animals, such as sheep, cattle, chickens and rabbits.

As mentioned above, these results recall the remarkable individuality in the response of animals to transplantation of tissues within the same species (L. Loeb). In long-inbred strains the transplants tended to survive for a longer period than in randomly chosen individuals, but completely successful results were obtained only in autotransplants. It is safe to assume that the parallelism between the individuality of blood cells and tissue cells in not accidental, especially in view of the fact that some of the blood factors are also present in tissue cells.

TABLE 2

	Blood								
	v. d Sch.	Ldst.	Henry	Mock	Ph.L.	Hdy.	Bl.	Kr.	A.W.
Group	O	O	A	O	A	A	A	O	O
Reaction for M	+±	O	++±	++±	O	++±	++±	O	+±
Reaction for N	+	++	O	+	++±	+	O	++±	+±
Reaction for A^1	O	O	+	O	O	+	O	O	O
Reaction for P (serum 1)	+	tr.	O	±	+	+	tr.	+±	O
Reaction for P (serum 2)	±	O	*	O	*	*	*	+	O
Serum of Ottenberg and Johnson	O	+	*	O	*	*	*	O	±

* Isoagglutination.

THE HEREDITY OF FACTORS A AND B

According to Bernstein, the blood groups result from the combination of any two of the three genes, O, A, or B, residing at a particular locus in a certain pair of chromosomes. All possible combinations result in six genotypes and four phenotypes (blood types) since the homozygous AA and BB cannot be differentiated serologically from their respective heterozygous forms AO and BO.

Genotype	Phenotype (Blood Groups)
OO	O
OA AA	A
OB BB	B
AB	AB

The various possible matings, together with the blood groups of children to be expected and those that are genetically impossible, are given below (Table 3). The combined results of numerous workers on 8700 families and 19,000 children collected by Lattes are in agreement with the Bernstein theory.

TABLE 3

	Parents	Children Possible	Children Not Possible
1.	OxO	O	A,B,AB
2.	OxA	O,A	B,AB
3.	OxB	O,B	A,AB
4.	AxA	O,A	B,AB
5.	BxB	O,B	A,AB
6.	AxB	O,A,B,AB	——
7.	OxAB	A,B	O,AB
8.	AxAB	A,B,AB	O
9.	BxAB	A,B,AB	O
10.	ABxAB	A,B,AB	O

Two facts are evident from the analysis of Table 3:

1. Children of group A cannot result from matings in which the dominant property A is absent in the blood of both parents; the same rule holds for the dominant property B.

2. In the mating O by AB, children of the parental types are excluded. More generally stated, in any mating in which one of the parents is an AB, children of group O are excluded. Parents of the recessive group O (genotype OO) cannot have children in group AB, both genes being dominant.

The genetic analysis of mating No. 4 is given to show why children of group O are possible from some of the matings when both parents are in group A, both parents being heterozygous for A. In this instance, the classical mendelian 3:1 ratio is obtained, three of the dominant group, and one of the recessive. The other matings may be similarly analyzed:

Parents	AOxAO
Gene in sperm or egg	A A or or O O
Children genotype	1AA 2AO 1OO
phenotype	3A's and 1O

All workers are agreed that in instances contrary to rule one, an absolute decision of non-paternity may be rendered. In view of one or two proven exceptions to rule two, in which a mother AB had a child with a blood that could not be differentiated from group O, non-conformity to rule two must be considered as strong evidence for non-paternity. An explanation of these exceptional cases compatible with the Bernstein theory was offered by Levine and also by Haldane.

These facts are available for the determination of illegitimacy and for the proof of non-paternity. If in any case of disputed paternity it can be established that the bloods of the mother, child, and alleged father are not compatible with the laws of heredity, this fact, then, constitutes proof that the man was falsely accused. Assuming 100 instances of a woman falsely accusing a man of being father of her child, it is possible to render a decision of non-paternity, and therefore exonorate the man in sixteen of the cases. This figure is only slightly diminished if one excludes the exceptions to rule two, since mating involving an AB parent are quite rare.

HEREDITY OF THE M AND N FACTORS

Although it is not yet ten years since the properties have been first described, the mechanism of heredity has been established as a result of studies carried out by workers throughout the world. The results of the examinations in 671 families and 2365 children are in agreement with the theoretical expectation based upon the view of Landsteiner and Levine that M and N are allelomorphic genes with equal dominance. This theory, in the first place, offers an explanation for the non-existence of the type M—N—. The genetic constitution for the three possible combinations is given below:

Phenotype		Genotype	
M+N—	(M)	MM	(homozygous)
M—N+	(N)	NN	(homozygous)
M+N+	(MN)	MN	(heterozygous)

The six possible matings with children to be expected are given in Table 4.

TABLE 4

Heredity of the Factors M and N According to the Theory of Landsteiner and Levine

Mating No.	Types of Parents	% of M	Children of N	Types MN
1	MxM	100	0	0
2	NxN	0	100	0
3	MxN	0	0	100
4	MxMN	50	0	50
5	NxMN	0	50	50
6	MNxMN	25	25	50

The genetic analyses of two contrasting matings, including the only one in which no exclusion is possible, are given below:

Parents	MNxMN
Gene in sperm or egg	M M or or N N
Children genotype	MM 2MM 1NN
Parents	MMxNN
Gene in sperm or egg	M N
Children genotype	MN
" phenotype	MN

According to this theory, the five following rules may be given:

1. The factor M or N cannot appear in the blood of a child unless it is present in the blood of one or both parents (dominance rule).

2. In matings in which both parents are homozygous for M, 100 per cent of the children are of the same type; the other two types are excluded (mating 1). The same rule applies for parents homozygous for N (mating 2).

3. In mating 3, in which one parent is homozygous for M and the other homozygous for N, 100 per cent of the children are of the heterozygous type MN; the parental types are excluded.

4. In matings 4 and 5, homozygous x heterozygous, the parental types are expected to appear in the blood of the child in the ratio of 50:50.

5. Where both parents are heterozygous (mating 6), children of the three types are possible in a ratio of 1M : 2MN : 1N. This is the only one of the six possible matings in which no exclusion can be made.

It is evident from the above rules that a child of the type M cannot come from a parent N; and a child N cannot come from a parent M. These considerations are based upon the fact that the homozygous form in contrast to A and B is serologically distinct from the heterozygous form; and in this respect, the MN system is superior to the AB system in giving more exclusions when the blood of the child and only one of the parents is available.

It has been calculated by Wiener that for the white population, an exclusion of paternity, based on the tests for M and N can be made in 18 per cent of all false accusations. Since the M and N factors are independent of A and B, serological proof of non-paternity at the present state of our knowledge is available in about one-third of all cases. Actually, Schiff, of Berlin, who has had the most extensive experience in this field, obtained about 15 per cent exclusions in an examination of 900 paternity cases. This value is about 50 per cent of the maximum, since in practice, as is to be expected, not every accusation is false.

Heredity of the Sub-groups A^1 and A^2 and the Factor P.—Although these properties are distinctly inherited, as was first shown by Landsteiner and myself, the exact mechanism of the heredity is not definitely established. In contrast to the blood factors A, B, M and N, there is not always a sharp distinction between bloods lacking and those possessing the factors. Consequently, these blood properties are not as useful from a practical point of view. Apparently, the property A^1 is dominant over A^2, so that $A^2 x A^2$ unions should result in 100 per cent A^2 offsprings; similarly P—x P— should give 100 P—; actually the experimental results are, on the whole, in harmony with this view.

LEGAL CONSIDERATIONS

Not only are these tests useful for exclusion of paternity in bastardy proceedings, but also in cases of interchange of infants. It has been calculated that 70 per cent of all such cases may be detected by means of tests for the four blood groups and the M and N properties.

European courts have been using these tests for more than ten years, and the list of countries recognizing these tests is ever increasing. Until very recently, American courts have been

hesitant in accepting the value of the evidence to be derived from these tests. However, in March, 1935, New York State passed a law granting authority to their courts to order these blood tests, "Wherever it shall be relevant to the prosecution or defense of an action, the court, by order, shall direct any party to the action and the child of any such party to submit to one or more blood tests, to be made by duly qualified physicians and under such restrictions and directions, as to the court or judge shall seem proper."

The writer has sponsored similar legislation in Wisconsin; and in August, 1935, the law was signed by Governor LaFollette. The Wisconsin Law states that, "Whenever it shall be relevant to the prosecution or defense in an illegitimacy action, the trial court, by order, may direct that the complainant, her child and the defendant submit to one or more blood tests to determine whether or not the defendant can be excluded as being the father of the child. The result of the test shall be receivable in evidence but only in cases where definite exclusion is established" * * * "Whenever the court orders such blood tests to be taken and one of the parties shall refuse to such test, such fact shall be disclosed upon the trial unless good cause is shown to the contrary."

In a law based upon scientific findings entirely outside the realm of the legal profession, it seems expedient that the essential feature of the test—proof for non-paternity—be incorporated in the wording of the law. As pointed out by myself in a recent unsigned editorial in the New York Law Journal, the wording of the New York State Law has been justly criticized, in a recent article by Flacks in the American Bar Association Journal, "on the ground that the court and jury, not recognizing the lack of real probative value in instances where the alleged father is not excluded, may be tempted unjustly to decide against the accused". The Wisconsin law, which was drafted with the aid of faculty members of the University of Wisconsin Law School, is so worded as to be free from this particular criticism.

Unless the court is given statutory authority, it is left to the discretion of the individual judge to decide whether or not the tests will be ordered. Legal authorities are agreed that the court is empowered with authority to order the individuals concerned to submit to the blood test. This procedure does not violate the constitutional privilege against self-incrimination.

A bill, the body of which is identical to that of the Wisconsin law, is being proposed in the New Jersey State Legislature. Professor Matson of the University of Montana has prepared similar bills to be considered by the Montana State Legislature. It is safe to state that in the very near future similar bills will be presented to the legislative bodies of many other states. There is an ever-increasing number of favorable comments on and references to the subject in current legal periodicals. Wigmore, one of the most noted legal authorities, discusses the scientific aspects of the subject at length in the 1934 "Supplement to the Treatise on Evidence". He writes as follows: "At the hands of expert specialists—but of specialists only—the tests ought to be more widely known and used in this country, within the limited scope of heir probative value."

At this point it may be stated that the technic for demonstrating M and N is rather involved, particularly so for the property N, so that the tests should be performed only by qualified and thoroughly trained serologists, preferably those affiliated with a medical school or the laboratory of a large hospital.

The popular knowledge concerning the significance of these tests is of great psychological value since it acts as a deterrent against false accusations. Consequently, one should expect in the future a lower incidence of exclusions, and such is the actual recent experience of workers in this field.

In a case recently referred to me by Dr. Martland, in which the husband denied the paternity of a child born during the interval of non-accessibility on his part, the court agreed to accept the results of blood tests. The husband appeared in my laboratory at the appointed time, but his wife failed to come and persistently refused to submit to the tests. On the strength of this, the court granted the husband a divorce, and exonorated him of any

responsibility with regard to the support of the child.

BLOOD STAINS IN CRIMINAL CASES

In 1903, Landsteiner and Richter demonstrated the stability of agglutinins in dried blood stains. Subsequent work has established an even greater stability on the part of the agglutinable substances in the stroma of blood stains. Accordingly, in favorable cases, it is possible to reconstruct the blood properties of any dried blood stain by determining its agglutinin and agglutinogenic content. Indeed, so far as the latter is concerned, this holds true even for the blood and tissue of mummies.

The presence of agglutinins in any stain is determined by testing the watery extracts of it with blood suspensions of groups A and B, and wherever possible, with blood cells of the accused and the victim. It is advisable also to include blood of group O in order to detect the presence of any non-specific agglutinating material derived either from dirt or some contaminating material. Direct tests for the presence of agglutinable substances in the stroma cannot be made, since dried blood cells do not exhibit isoagglutination. However, they still retain their capacity to specifically absorb the homologous antibody. Only small quantities of dried blood are required for these tests. Of course, preliminary precipitation tests are required to prove the human origin of the blood stain.

Thus it is possible to obtain evidence which may or may not be compatible with the testimony of the accused. In several such cases reported by Lattes and Popoff, the final decision rested entirely on the outcome of such tests, which either proved the falsity of the testimony of the accused, who subsequently confessed; or disproved the claims of the prosecution, thus establishing the innocence of the accused.

The properties M and N have also been shown to resist environmental conditions of drying, and Lauer has reported such tests in blood stains. Reference may again be made to the presence of the A and B factors in soluble form in saliva, seminal fluid, mucus, and sweat. Accordingly, in certain criminal cases, the dried saliva on cigarette stubs, or clothing contaminated with sperm cells or seminal fluid, become available for investigation.

These tests will certainly be used more extensively in criminal cases, and especially so with the improvement of the technical procedures involved. At this point, it is appropriate to mention the suggestion of Merkel, that routine blood tests be made on the victims of fatal assaults so that this information will be available along with the autopsy findings.

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HISTAMINE—ITS PRACTICAL APPLICATION AND THE THEORY OF ITS ACTION

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An animal organism, say, your body or mine, supports a laboratory, the products of which might well cause organic chemists to be envious. It is capable of producing with efficiency and perfection intricate chemical compounds, some of which have never been duplicated in vitro. The organism manufactures its own insulin, epinephrine, thyroxine, and hypnotoxin. It can split proteins into amino acids; and then through the process of metamorphoresis put them together in perfect order, the finished product being specific ani-

mal protein. It often happens that whole molecules of protein will escape the processes of assimilation and metamorphoresis and will circulate through the body as antigens, producing antibodies, and after a time developing oversensitivity to their own kind.

Much has been written concerning the nature of both acute and protracted anaphylactic shock. Its symptoms are familiar to all of us. The protracted form has many varieties, depending on the part where the phenomena are manifested. Should it be the nasal mucosa, the condition is described as hay fever or rhinitis; when the lung is the seat of the reaction, asthma results; with the skin, it is urticaria or eczema; and in the gastro-intestinal tract, the diagnosis will be indigestion, or enteritis, or mucous colitis. Such symptoms in their mildest manifestations are somewhat disturbing; when severe, they are alarming and even dangerous.

HISTAMINE

It is pointed out here, I am counted among those immunologists holding to the opinion that anaphylactic shock is due to the liberation of histamine or histamine-like substances. Histamine, as you know, is an amine of histidine, and can be prepared by the decarboxylation of this amino acid. Chemically, histamine is B-imidazol-ethylamine, and it is found in all animal tissues. Histamine is liberated by the action of some thirty different types of putrefactive bacteria. In fact, one will find histamine wherever protein is broken down into its component amino acids in the presence of putrefactive bacteria.

Barger and Dale, in 1910, isolated histamine from ergot, and also found it in the intestinal mucosa. Three years previously, in 1907, Windaus and Vogt prepared the substance synthetically by a decarboxylation of histidine. A modern method of making histamine from histidine is by the process of subjecting the amino acid to the influence of ultra-violet irradiation.

Dzsinich has called attention to the great similarity between histamine shock and anaphylactic; and on the basis of this observation assumed that histamine plays a part in allergic conditions. Subsequent investigations made in connection with this hypothesis have, according to Dzsinich, corroborated the assumption of the important rôle of histamine in allergic reaction, namely, of the histamine which is liberated by the cells in the sensitized organism. It must be assumed that in asthma, histamine is liberated by the vascular cells of the bronchi; in urticaria, by those of the skin; in hay fever, by those of the nasal mucous membrane; and in migraine and epilepsy, by the vascular cells of the brain. The histamine and histamine-like substances thus liberated elicit endogenously the local and general symptoms of these disorders.

It has been observed that the histamine content of the guinea-pig lung decreases from 10 to 45 per cent following anaphylactic shock. This shows that the substance resulting from the meeting of antibody and antigen is utilized during the process of the shock. The experiments of Morris Smith and myself show that one may cause the death of a sensitized animal by administering half a lethal dose of antigen and half a lethal dose of histamine. The urine during pregnancy contains an increased amount of histidine, and it has been the observation that such conditions as asthma, eczema, arthritis show marked improvement during the period of gestation. Such phenomena lead one to speculate that the increased elimination of the amino acid results in a lessened quantity of histamine in the tissues and, as a consequence, dissipation of anaphylactic shock and the absence of symptoms common to such states.

One is also led to wonder whether the results obtained with the Aschheim-Zondek test are not due to the large amount of histidine contained in the urine during pregnancy. It is also interesting to speculate whether many of the pathological processes of a somewhat mysterious nature are not due to the presence of histamine in the various tissues. In this connection, it is interesting to recall the summary given by Dale in the third Croonian Lecture, which is in effect an explanation for the similarity between anaphylaxis and histamine shock in various species. In anaphylactic shock, it is postulated, intracellular reaction between

antigen and antibody causes cellular injury, which liberates histamine and other substances. During the menopause in the human, it is believed that the ovaries secrete histamine into the general circulation and cause such phenomena as hot flashes, headache of the migraine type, and so-called nervousness or state of undue excitability.

PHYSIOLOGICAL ACTION

The physiological action of histamine is very interesting. In animal experimentation its effects vary with the species. In all species, the substance acts as a stimulator of the autonomic nervous system, and exerts a pronounced effect upon smooth musculature, as an instance, the uterus. Histamine is active on the isolated muscular fibers of the uterus and intestines of the embryo guinea-pig in concentrations of 1:25,000,000, or even as low as 1:500,000,000. In the guinea-pig, intravenous injection of the substance is followed within a few minutes by a fatal spasm of the bronchial muscle which prevents expiration.

Histamine accelerates the contraction of the heart, and will accentuate its murmurs. Centrally, the drug produces a degree of depression which is greatly overshadowed by the symptoms arising from the peripheral organs. It increases gastric motility and provokes contraction and evacuation of the gall-bladder. Myosis follows its administration. There is increased secretion of lacrimal, bronchial, salivary and intestinal glands, and also the pancreas, causing transient hypoglycemia. The chlorides of the blood decrease following injection of histamine. Diuresis and hyperadrenalinemia are also caused by the substance. An interesting feature of histamine is that general anesthesia greatly modifies its action, reversing it at times. In this connection, it is pointed out that in animal experimentation, general anesthesia has been found capable of modifying or preventing anaphylactic shock.

SKIN PHENOMENON

When histamine is applied to the skin, there occurs a phenomenon known as *triad of Lewis*. It is characterized by local edema, and an area of redness bordered by extreme paleness of the skin. An elevated local skin temperature persists for a period of from two to eight hours. The local reaction of skin tests on every allergen may be explained by the presence of a complex group which, when decomposed in the skin of a hypersensitive individual, forms histamine.

Allergy toward chemical substances may be considered as a sensitivity to a combination or compound with protein. The so-called saturated compounds, like the parafins, do not combine with proteins, and therefore are never the cause of allergic phenomena. Chemical substances included among the unsaturated compounds combined with proteins of the body cause an alteration in them, and by such reaction produce autoproteins which sensitize the organism. It is upon such a basis that the anaphylactic theory of morphine addiction is founded.

In some infectious diseases, like pneumonia, one observes a terminal stage,—an edema of the lungs. An identical condition is observed in guinea-pigs following a dose of histamine. The primary stage of pneumonia with accompanying high fever may be looked upon as an attempt to destroy antibodies, the last stage in which hypothermia is manifested in indicative that the "battle" has been won by the antibodies and antigens with the resulting production of histamine.

Some pathological states result from protein destruction, while in other instances such conditions are due to the failure of protein to break down and to be subsequently assimilated. The failure of an organism to produce amino acids through hydrolization of proteins during the process of digestion will result in deficiency diseases. It is upon this hypothesis that the histidine* treatment for peptic ulcer is founded; and it seems reasonable to expect that, when a specific treatment for cancer is discovered, it too will be based upon the action of amines or amino acids.

It has been established that local cerebral anaphylaxis can be produced by local sensitization with horse serum or white of egg. A dog so sensitized will develop symptoms of local cerebral irritation upon administration of the

* Larostidin.

antigen intravenously. The phenomena depend on localization of the focal sensitization in the cerebrum, and may be the key to focal brain disturbances such as Jacksonian type of epilepsy, idiopathic epilepsy, migraine, and tics. It may be that the liberation of histamine is responsible for these phenomena. In this connection, it is pointed out that in cerebral hemorrhages, the clot liberates histamine which, in turn, may explain the lowering of blood pressure in such cases. It has also been observed that, in patients with paralysis, histamine reactions are absent in the affected areas. In cases where there are indefinite areas of skin lesions due to brain or spinal cord disease, the affected areas can be outlined by means of histamine tests.

DESENSITIZATION TO HISTAMINE

In the light of our present knowledge, it would seem that the so-called skin tests for allergy are superfluous. If histamine is the final product of reaction between antigen and antibody, then desensitization to histamine is the logical procedure in treating allergic conditions. This we are doing in our allergy clinic. For pruritis, migraine, and certain varieties of arthritis, minute quantities of histamine are injected. Asthma is treated by scarification. Our results have been very encouraging as various members of the staff will attest. Among our cases, which include asthma, hay fever, eczema, migraine, and other allergic conditions, are many which responded to histamine after various other agents failed to elicit a satisfactory result. Many cases of sciatica have also responded to the therapy. For an explanation of histamine action, we must go to the works of Genzaku Obo, Moldovan, and Zolog. One of the best antianaphylactic agents is the serum of rabbit which is powerful in its ability to destroy histamine. The serum of man does not destroy histamine.

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CEREBRAL INJURIES

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A casual glance backwards through past decades of medical history will impress every physician with the fact that the problems of our profession have varied in proportion to the social, economic, and industrial changes which have occurred in the development of the human race.

We are all aware of the fact that, during the present decade there has been an appalling increase in the number of head injuries. This, together with the constant discussion and differences of opinion relative to the clinical manifestation of cerebal pathology, has placed this group of cases in the front ranks of present-day medicine.

The frequency of their occurrence, the high mortality, the resulting disability, and I might add, the eventual litigation which usually accompanies such accidents, make it imperative that every physician who accepts the responsibility of treating these cases, shall have thorough understanding of the diagnostic, therapeutic, and surgical care of these patients.

Accurate statistics of the total number of cerebral injuries, including fractures of the skull, are unavailable; but a comparison of figures will give us an approximate idea of their frequency. Swift [1] estimates there are approximately 112,000 skull fractures in the United States yearly. The Travelers Insurance Company reports 36,100 deaths from street and highway accidents alone. Approximately two-thirds of this number died of cerebral injuries. A study of Munro's [2] mortality table places the death rate at approximately 24 per cent, which would justify the conclusion that there are approximately 75,000 cases of craniocerebral injuries due to traffic accidents alone. If these figures are added to the miscellaneous group, we have some idea of the great loss of human life and health as a result of cerebral injuries.

The purpose of this presentation is to briefly discuss some of the problems that have arisen during the examination and treatment of head injuries, as time and space will not permit a complete study of the entire subject.

I wish to emphasize the fact that there is no condition in medicine where the value of an *accurate history,* combined with *frequent clinical observation,* is more fully appreciated. The percentage of cases in which this frequently means the difference between success and failure is not small. Again, where litigation follows, it furnishes the court and the attending physician with an accurate record of the injured's condition.

In order to establish a working basis for the co-relation of the clinical findings, I think it imperative at this time to establish a starting point for the clinical classification of these cases; and, of course, the first condition that comes to mind is that of concussion.

CONCUSSION

I know of no word in medical terminology that is more ambiguous, or that has more varied interpretations, than the term *concussion.* You may think it somewhat presumptious for me to attempt to define, or establish the meaning of the word at this time; but since it includes so many and varied interpretations, clarity demands that I do so.

In the works of Dr. Miller,[3] I have found what seems to be a concise, logical and satisfactory clinical interpretation of the term concussion.

> "The essential symptoms of concussion undeniably depend on a physiological disturbance, and it has never been proven that these have been caused by anatomic lesions. Pathological lesions may be coincident with concussion, but clinically should be considered as separate from concussion."

In other words, concussion may occur with or without organic changes in the brain.

Simple, or uncomplicated, concussion, is immediate in onset, and tends to terminate in a spontaneous recovery. The term should imply a group of symptoms which are a result of temporary inhibition of cortical function, with or without stimulation or inhibition of one or more of the medullary centers; but which are not accompanied by pathological lesion. It is immediate in onset, and tends to a spontaneous recovery without sequelae.

Clinical signs, of course, vary with the degree of concussion. In its mild form there would be the simple loss of contact with one's environment. If sufficiently severe, the medullary areas of the brain are inhibited. We would then have signs of inhibition of the respiratory, cardiac, and vaso-motor centers, resulting in loss of consciousness, shallow respiration, rapid pulse, falling blood pressure, pallor, clammy skin, etc.—in other words, a clinical picture of *cerebral shock*.

CEREBRAL TRAUMA

The so-called concussion group should be differentiated from, and is frequently accompanied by, the next clinical group, namely, *cerebral trauma,* where we have pathological changes within the cranial cavity, and resulting in signs of compression.

In very recent injuries, the differential border line between the concussion group and the compression group of symptoms is frequently somewhat confusing. In other words, there is an over-lapping of clinical findings which I shall discuss later,—a so-called intermediate period during which neither the signs of concussion nor the signs of compression become definitely manifest.

In the compression group proper, the symptoms develop at a more remote period, and are characterized by the signs of increased intracranial pressure. The patient may, or may not, be unconscious; and as in concussion, the clinical findings increase with the gravity of the injury. As stated above, the clinical findings are the opposite to those of concussion. The volume within the skull having been increased by oedema or by petechial or gross hemorrhage, there results an increase in the intracranial pressure.

Nature, in her effort to maintain the cerebral compensation, responds by a rise in blood pressure. The pulse is full and strong; and as the blood pressure rises, it becomes more slow, and the respirations are full and deep. It can be seen therefore that, shortly following an accident where there has been a concussion associated with a cerebral injury, we frequently have a clinical state where the signs of *concussion* are being neutralized, as it were, by those of *compression.* This accounts for the fact that some authorities have expressed the opinion that the blood pressure and pulse changes do not have the clinical value that others attribute to them. I believe that this is particularly true a short time following a cerebral injury; but I would also call your attention to the fact that, the more remote those symptoms make their appearance after the signs of concussion have subsided, the more valuable they become from a clinical standpoint.

I would also like to emphasize the fact that this so-called overlapping of concussion and compression symptoms account for those cases of fairly rapid death, in which the patient is deeply unconscious, but presents a fairly normal pulse, safe blood pressure, normal respirations, followed by a sudden change in which there is a rapid failure of cerebral compensation and death,—thus emphasizing the great importance of frequent and accurate observation of these cases for a few hours following admittance to the hospital. Autopsy reports reveal the fact that the majority of these cases are hopeless; but I am convinced that a few are lost by our not taking cognizance of this clinical possibility.

So far, I have discussed only the three cardinal changes: the blood pressure, the pulse rate, and the respiration, in cerebral injuries. At this time I would call your attention to several other clinical findings which are of untold value in ascertaining the clinical status of these cases and in directing their treatment.

STATE OF CONSCIOUSNESS

The first that I would consider is the state of consciousness of the patient. Complete un-

consciousness, immediately following a head injury, does not necessarily imply a brain injury; but a complete unconsciousness which persists after the signs of concussion have disappeared, is indicative of brain trauma. Of course, this fact becomes more definitely established after the signs of compression have developed. A restless, or barely conscious patient would indicate that the individual is on the border line in relation to sufficient cerebral compensation to maintain consciousness. Where the patient has been definitely unconscious, and becomes irrational and restless, it of course indicates cerebral compensation is returning. But where there have been intervals of consciousness, it is a very definite indication that there has been a break in the cerebral compensation, and that the intracranial pressure is rising.

TEMPERATURE

The temperature is frequently of some value. It is not uncommon to find a temperature of 100 degrees, or 101 shortly after a cerebral injury. A rising temperature, associated with definite signs of compression, is a frequent forerunner of failure of cerebral compensation. A persistent temperature of 102 or 103 is frequently associated with free blood in the subarachnoid spaces; and where this exists, the thermic reactions are similar to those of free blood within the peritoneal cavity. This condition can often be verified by an increased leukocytic blood count.

EYES

As to the eyes, frequent observations and clinical interpretation of the pupillary reactions is of untold value in the study of cerebral injuries. Excluding the ocular diseases, there are two efferent nerves controlling the muscles of the iris, namely the *oculo-motor,* and the *sympathetic*. The reactions of the iris in the state of mydriasis or myosis, being either spastic or paralytic, depending on the efferent system affected. For example, the stimulation of the oculo-motor nerve results in a contracted pupil, a so-called *spastic myosis*. A paralysis of the sympathetic causes a contracted pupil, a so-called *paralytic myosis*. A paralysis of the oculo-motor causes a dilated pupil, or a paralytic mydriasis; whereas a stimulation of the sympathetic causes a so-called spastic mydriasis.

Here again, by frequent observations we are able to see an overlapping of nerve impulses to the iris. For example: if a case is seen early during the period of concussion or cerebral shock, where the influence of the sympathetic is predominent we frequently find a dilated pupil, due to the stimulation of this nerve,—a so-called spastic mydriasis. At a later period, we may find the pupils contracted, due to an irritation of the oculo-motors,—a so-called spastic myosis.

The use of cocaine instilled in the eye is of some value in differentiating between a so-called paralytic and spastic myosis, in that a spastic myotic pupil will dilate from the effects of the cocaine. Unequal pupils, associated with signs of increased intracranial pressure, suggest intracranial hemorrhage on the side of the dilated pupil. Again, injuries to the oculo-motor, the sympathetic, or the optic nerve, may cause unequal pupils, but in the absence of signs of cerebral compression, it is not a sign of intracranial hemorrhage.

VERTIGO

Due consideration should also be given to the ophthalmoscopic findings and the various changes in the ocular muscles, but time will not permit me to discuss these in detail.

The question of vertigo in cerebral injuries, is, of course, variable, depending on the severity and the location of the lesion. Almost all cases of cerebral contusion or compression complain of some form of equilibratory disturbance. This disturbance is usually of a mixed central and end-organ type, rather than an involvement of an end-organ alone, except in cases where the pathology lies in these end-organs.

The aggravation of vertigo due to changes in posture or positions of the head, particularly in the milder forms, is due chiefly to labyrnthine disturbance. Associated with the vertigo, we have the nausea and vomiting, which are varying degrees of irritation of the vagus nerve.

In considering the above clinical signs, I have tried, as far as time permits, to deal with the average case, and avoid the various localizing clinical findings, which would necessitate a discussion of many of the neurological, otological, and ophthalmalogical phenomena; but I would remind you that in order to obtain an accurate opinion, it is of course necessary to include all of these studies when indicated by the particular case under consideration.

TREATMENT

In reference to the treatment of these cases, I wish to emphasize the fact that there is no standardized treatment for head injuries. Every case is a law unto itself. It is of paramount importance to consider first: what nature can do, or what nature is doing, to correct this condition; and then to take such steps, if necessary, to assist her in her efforts to relieve it. It must be remembered that nature *has* a means of controlling intracranial pressure. As oedema or hemorrhage increase the contents of the skull, she presses out the cerebrospinal fluid bulk, and gets a space adjustment equal to the volume or sufficient to maintain cerebral compensation. We recognize the fact that she has reached the limit of self-adjustment when the symptoms of cerebral compression or increased intracranial pressure make their appearance.

Again, except in specific instances, such as depressed fracture, or compound fracture, and fractures extending into the various sinuses, we are interested, not in the presence or absence of a skull fracture, but in the state of cerebral function or the ability of the brain to perform its functions following an injury.

DEHYDRATION

In the treatment of these cases, the first condition that we have to face, is that of cerebral shock. I personally know of no drug that is so spectacular or effective as the use of a 50 per cent hypo-tonic glucose, given intravenously. This treatment, augmented by the prone position, hot water bottles, blankets, and other forms of stimulation, if necessary, will usually aid materially in the patient's recovery from shock. During this state, the patient should not be disturbed. During the period of compression and increased intracranial pressure, the head of the bed should be elevated, and we should utilize the various methods of dehydration.

In applying the so-called methods of dehydration, I must say that I cannot agree with the ultra-conservative group, nor have I been able to go the limit as suggested by those who are more radical in their methods of treatment. Dehydration has a definite value, and does produce a lowering of intracranial pressure. However, I would caution against extreme dehydration, especially in old people. Munro [4] states that toxic dehydration occurs in 2.6 per cent of the cases. It is certainly not an infrequent complication; and unless one is alert to the clinical signs of the condtiion, the result will be an unnecessary fatality.

LUMBAR PUNCTURE

In the milder forms of cerebral compression, the limitation of the fluid intake, and the use of a 50 per cent solution of magnesium sulphate by rectum, will usually be sufficient to keep the patient comfortable.

In the more severe forms we must resort to lumbar puncture. As stated by Sharpe,[5] this procedure is rapidly becoming a more routine part of our examination and treatment. It should not be done while the patient is suffering from shock; and we should, if possible, ascertain the location of the injury, since it is hazardous in cases of injuries to the upper cord, the medulla, and the cerebellum. If cautiously used, its value is both diagnostic and therapeutic. From a diagnostic standpoint, a very small amount of fluid is removed. The intracranial pressure should be accurately measured with a spinal manometer, and the presence or absence of blood in the cerebrospinal fluid ascertained. From this point of view, I believe it is a comparatively safe procedure, but *not* devoid of hazards.

The use of lumbar puncture for treatment, however, is an entirely different question. In this procedure, it is necessary to remove large amounts of fluid, particularly where the intracranial pressure is high, or where there is considerable blood in the spinal fluid. Under these

circumstances, in the presence of pathology at the base of the skull, it may become a very dangerous procedure. However, I believe its value in severe cases is certainly superior to that of intravenous glucose and rectal dehydration by magnesium sulphate, in which there is a tendency for a reverse flow of the body fluids from the arterios and perivascular spaces back into the cerebral cell proper. In other words, the reaction is equal to the action.

Apropos of spinal drainage—in cases of bloody fluid, I would emphasize its great therapeutic value in this condition. It removes the blood cells from the piarachnoid spaces, improves the circulation of the spinal fluid, and prevents the formation of clots which are the probable cause of the so-called pachymeningitis, or which in turn frequently result in cerebral oedema.

SEDATIVES AND RESTRAINT

At this time I would also call your attention to the fact that during the semiconscious, wildly excitable states, following the severer forms of injury, the use of nerve sedatives, or opiates, are of little avail, and in fact do harm. Also restraints, such as tying of the hands and feet, straight jackets, etc., should be avoided, if possible. Of course, in this state, constant attendance is necessary; but I am convinced that restraint greatly aggravates the mental excitement, and causes struggling on the part of the patient; thereby defeating our objective, namely: a quiet, composed patient. Because of lack of sufficient nurses, it is frequently impossible to obtain this in the wards of our hospitals. Several times I have ordered restraints removed and within half an hour noticed a more composed and quiet patient, which of course, is the thing to be desired.

The question of treatment cannot be completed without considering surgical intervention. Dandy,[6] of Baltimore, says the major portion of cerebral injuries, approximately 70 per cent, will recover if left alone, or treated by the above methods. Less than 10 per cent can be saved by operation.

The surgical indication in head injuries are fairly definite.

First, the compound, comminuted or depressed fractures require early surgical care, the debridement operation being performed. Of course, no surgical procedure should be attempted during the period of cerebral shock.

Second: The ordinary depressed or comminuted depressed fracture which has not been compounded, is less apt to result in infection, and the surgeon should be guided by the state of the cerebral function.

Third: The extradural or subdural haematomata require operation; but here again, the condition of the patient is the sole guide as to the selection of the time of operation. The decompression operation is of last resort in cases where we have applied all methods of lessening the pressure, and having failed to bring about a return, or to maintain the normal cerebral function. I might also add that the decompression operation is occassionally indicated at a later period in cases of so-called chronic, cerebral oedema, due to a traumatic pachymeningitis, petechial hemorrhage, etc.

CONCLUSIONS

In conclusion I would say that *first*: Cerebral injuries are markedly on the increase in this country. The major portion of the fatal accidents are occurring in rural sections, remote from the large medical centers. It is essential that every doctor be accurately informed on the diagnosis and treatment of this group of cases.

Again, the majority of these cases are later considered from a legal angle, in which the question of the amount or extent of permanent cerebral disability has to be determined. It is imperative, therefore, that hospital reports, diagnosis, and history be accurately recorded. Apropos of this, I would urge that the term concussion be used in the sense of a simple concussion; and that where a patient presents symptoms other than simple concussion, for the sake of clarity, we should use the term *concussion plus cerebral contusion,* and whatever the clinical signs would indicate the cerebral trauma to be.

Second: I would call your attention to three clinical states in the more severe type of cerebral trauma: (A) the period of concussion

with its characteristic clinical signs. (B) The intermediate state in which the signs of concussion and compression over-lap and frequently neutralze each other. (C) The state of cerebral compression, which is a more remote period and identified by fairly constant characteristic findings.

Third: In reference to the treatment, the use of 50 per cent glucose solution has its greatest value in cerebral shock. The various other forms of dehydration, if used conservatively, are of definite value in combating cerebral compression.

Fourth: Lumbar punctures should be considered from a diagnostic and therapeutic standpoint, the hazards increasing with the amount of fluid withdrawn. In the absence of certain types of cerebral injuries, and with due allowance for the period of time between the accident and the lumbar puncture, it becomes one of our best methods to reduce and relieve increased intracranial pressure.

Fifth: And lastly, that toxic dehydration is not infreuqently seen with prolonged unconsciousness even in the absence of dehydration therapy.

DISCUSSION

DR. THOMAS FITCH, PLAINFIELD

I congratulate Dr. Hurff on the well-prepared paper we have heard this morning. Its outstanding feature is its simplicity. He has put this complicated subject into a few words, and made it most interesting.

In dealing with head injuries, to me the most essential point to bear in mind is the attempt to distinguish between intra- and extra-cerebral hemorrhage. The one is purely surgical, and the other purely medical.

We must always be on the alert for *focal signs,* resorting to neurological examinations, not too extensive, but observing all of the reflexes, pupillary responses which Dr. Hurff has already given us in excellent style, and watching for any progress or change on the two sides of the body as if we can distinguish between intra- and extra-cerebral hemorrhage we can do much toward saving life.

Eye grounds used to be considered essential in distinguishing between intra- and extra-cerebral hemorrhage. Fundi are often misleading, and we cannot depend on the production of edema to determine hemorrhage.

Probably the most important procedure which we can follow and have available to make final decision is through *encephalography.* This should not be done in the early stages but in cases remaining border-line for long periods of time—often in a state of irritability for ten days or two weeks. This is only a suggestion when no other way of distinguishing between the types of hemorrhage is possible. In our experience, the results have sometimes been dramatic and entirely satisfactory in cases where extra-cerebral hemorrhage has occurred and could not be diagnosed without encephalography.

Decompressions are extremely disappointing. The outline presented has been far more successful, and I doubt if many cases are benefited by decompression.

Dr. Swift, of Seattle, gave the first rational outline of dehydration and we are indebted to him for cushions or reservoirs, as he calls them, which can be controlled by dehydration.

Dr. Barkhorn mentioned that in the second stage of injury, if concussion is present when doing spinal fluid puncture, do not remove fluid if the pressure is too high. What pressure is too high?

Dr. Barkhorn: Thirty on the manometer.

Dr. Hurff: There is not much that I can add, but I would like to say a few words on dehydration. As we all know, there has been a lot in medical literature and there is a tendency on the part of a lot of men as soon as a patient is admitted to give magnesium sulphate by rectum, and to limit fluid intake.

I am leading toward the other side—that where the spinal pressure is normal or near normal, even though the patient is in a deep depression state, I let them alone. When we pull out fluid, we get a low pulse rate and lower the pressure, and the dehydration does harm.

This follows up with the question of *toxic dehydration.* We can go too far and cause toxic dehydration in a patient. We often forget that the patient comes into us unconsclous and probably the interne gives two or three doses of magnesium sulphate, and cuts down the fluid intake. The temperature rises, the pulse ls rapid, and he goes into a state of toxic dehydration. We must study these patients carefully before applying these methods, and make sure there are indications for dehydration. Otherwise let the patlent alone.

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ORTHOPTIC, OPERATIVE, AND COMBINED METHODS OF TREATING CONVERGENT SQUINT

By Linn Emerson, M.D., F.A.C.S., Orange, N. J.

Read before the Section on Eye, Ear, Nose and Throat at the Annual Meeting of The Medical Society of New Jersey at Atlantic City, June 4, 1936.

The predisposing effect of hyperopia and astigmatism as suggested by Donders, and of deficiency or absence of the fusion faculty by Worth, are too well recognized by most ophthalmologists to make necessary any discussion or controversy.

Since there are many cases that are not suitable for orthoptic treatment, it is essential that care and judgment be exercised in the proper selection of cases, and that all the features and attendant circumstances be given due consideration. If this is not done both the surgeon and the family will be disappointed and dissatisfied.

Congenital anatomical defects of retina, choroid, iris, cornea, or ocular muscles, opacities of the cornea, birth palsies, nystagmus, high degrees of myopia or astigmatism and excessive anisometropia or antimetropia are some of the rare causes of convergent squint, but about 75 per cent are concomitant monolateral, with amblyopia ex anopsia, and are suitable for orthoptic treatment. About 10 or 15 per cent are alternating, and while amenable to this plan of treatment, are much less favorable candidates. The refractive error is quite likely to be nearly equal in the two eyes, often comparatively small in amount, accompanied by little or no astigmatism, and the fusion faculty is dormant or entirely absent. Vision is often practically normal in each eye, and protracted treatment and tests fail to elicit diplopia or the slightest tendency to fusion. Despite all these factors a certain number of them do respond to a plan of treatment which I shall later outline.

The practice of medicine is an art as well as a science, and nowhere is it better illustrated than in this particular field. Confidence and coöperation must be secured, or the results will be unsatisfactory. Undoubtedly this is one of the reasons why this plan of treatment has gained so few adherents.

During the first ten years of my work in this field nearly all my patients were clinic cases, and the lack of coöperation due to ignorance, indolence and poverty was at times most discouraging; but as the list of cures grew, so did the number of patients under treatment.

COOPERATION OF PARENTS

At first I took every squint case that presented itself, and frequently failed for lack of discrimination in the selection of cases suitable for this plan of treatment. No matter how favorable the case for treatment, if the parents show ignorance, prejudice, indolence, or are too poor to buy apparatus or glasses and keep them in repair, little success will attend the most persistent and painstaking efforts on the part of the surgeon.

Many parents have been given bad advice not only by the laity, but by physicians, and even oculists. Owing to the prejudice against the wearing of glasses by small children many come so late that the treatment is greatly protracted, and vision in the amblyopic eye can not be fully restored.

The majority of this type of squints appear between the ages of one and six years, with the largest number occurring before the fourth year of life. The earlier treatment is undertaken, the more quickly cure can be accomplished, and the better the chances of partial or complete restoration of vision in the squinting eye. I have been able to have one child wear glasses at the age of nine months, another at fourteen months, and a very large number under the age of two years.

At the first visit every detail must be fully explained to the parents, care being taken that no promise of cure be given. I frequently tell patients that any doctor who promises to cure any condition whatsoever is a fool or a knave.

The treatment is likened to orthodontia, or hip disease, and may consume months or even years. The question is often asked if, after the squint is cured, the glasses may be discontinued. It must be explained that the error

of refraction is so great that, even had convergence not developed, glasses for constant wear will in all probability be required by the time the child reaches grammar school age.

So much time and patience is required for this work, it can not successfully be carried out during regular office hours. I have therefore set aside two afternoons each week, and give half hour appointments. Parents who are hesitant are permitted to come and observe, and talk with the parents of children under treatment.

The first step in the treatment of any squint case is to ascertain the refractive error under atropin cycloplegia. If it is decided that no glasses are indicated, the question of what type of operation for cosmetic effect, and the time of its performance, can be decided without undue haste.

The multiplicity of operations that have come and gone, and that are now being performed, prove that any one or more operations that will permanently correct the defect may be performed on the individual choice of the operator. If the refractive error is more than two diopters, full correction should be ordered and worn, in order to ascertain what effect may be accomplished.

TREATMENT

As most cases treated are monolateral with some degree of amblyopia, the first thing to accomplish is to improve the vision in the amblyopic eye. The best way to accomplish this is by complete occlusion of the good eye, but seldom can this be done with any degree of success. If an opaque lens is given, the child looks past it to one side. If any loose patch is used, it is pushed up as soon as the child is out from under observation. An adhesive cover of any sort is resented by both the child and the parents. Many children so covered will either cry or sit down and sulk, refusing to play or do anything. Both the child and the parents are greatly embarrassed by the unfavorable comment and ridicule of relatives, neighbors, and friends. This at once brings about an unfavorable attitude towards the doctor which may serve to terminate the treatment. The whole plan of treatment must be worked out as a sort of game.

For this reason the best plan is blurring the good eye by the installation of one per cent atropin each morning. Several times a day a small piece of absorbent cotton is slipped between the good eye and its lens, and pictures, blocks, letters, etc., are observed and read by the poor eye. The parents are urged to note any improvement in vision during these periods. Some children soon become so tractable that they will wear the cotton several hours each day.

At the earliest possible moment visual tests with charts or letters should be devised, that the parents may observe the improvement in vision in the amblyopic eye. It is surprising at what an early age a child can be taught a half dozen or more letters of the alphabet.

TRAINING THE FUSION FACULTY

Attempts to elicit fusion can be begun by the age of two and often before. The various instruments devised for this purpose may all be tried. Some patients do better with one device than with another. The amblyoscope, the telebinocular, and the Cruise stereoscope with rotary prisms are most frequently used. I have a pair of Risley rotary prisms made so they can be adjusted to the telebinocular.

I think I possess nearly all the stereoscopic charts that have been devised for this work. The Keystone sets are most elaborate and are constructed for perfect stereopsis, but for routine work I use Kroll's and the ones made in three colors by Hamblen of London. The Hamblen charts are particularly valuable in very young children who can soon be taught the three colors, green, yellow, and red, and the presence or absence of fusion can be ascertained at an early age.

As soon as satisfactory fusion is obtained in the office, a cheap Brewster's stereoscope with any of the various charts is given for home use.

As vision in the amblyopic eye improves, the parents state that the good eye turns when the glasses are off, and often express concern. This is a most hopeful sign, but the atropin is continued until the good eye turns with the glasses on, when the vision in the amblyopic eye is usually 20/40-20/30 or better, and the

squint may have entirely disappeared when the glasses are worn.

At this time the frequency of the use of atropin in the good eye is lessened, or its regular but less frequent use is begun in the poor eye. In the latter event + 2.00S segments are added to enable the performance of school work.

This plan of atropinization of both eyes and the addition of segments often brings remarkable results in cases of alternating squint.

Dr. Wendell Reber wrote an article on this plan of treatment in 1911, and reported good results. He was unaware of the fact that I had mentioned it in 1906 in a paper read before the New York Academy of Medicine.

When the development of fusion lags without the aid of prisms, and the squint remains more than 20°, a cautious tenotomy on the internus of the squinting eye correcting about one-half of the deviation often hasten the development of fusion and the case goes on to complete cure.

As a matter of fact I now seldom perform any squint operation other than a guarded tenotomy. It can be done in the office without hospitalization, and in young adolescents who wish only cosmetic results and object to loss of time, excellent results may be secured if care is exercised and overcorrection avoided.

DISCUSSION

LEGRAND H. HARDY, M.D., NEW YORK CITY

Orthoptic training is a method of developing or restoring the normal, integrated functions of the eyes by means of graded exercises. Its value in the treatment of strabismus "is subject to extreme opinions, some claiming almost invariable success, others doubting the possibility of any. The truth lies between the two. It is of great value in suitable cases when made sufficiently intensive and prolonged." The quotation is from Ernest Maddox.

I believe fifty per cent is not a generous estimate of the number of squinting children who may be aided by this form of treatment: the aid consisting in a more complete development or re-establishment of the ocular functions than that given by surgery alone. I am convinced that some children suffering from squint may be relieved of all their symptoms by orthoptic training; and that many of them who require surgical treatment as well will be more completely and permanently cured if the operative treatment is supplemented by attempts to develop and integrate the functions of the eyes.

Functional training under the direction of a judicious surgeon, who may operate when conditions are most propitious, offers the greatest hope to thousands of afflicted patients. As such it should be in the hands of the medical profession where it is least subject to abuses. It is a social misfortune that it has been exploited by those with neither the ability nor honesty to accept its true worth, and who by exaggerated, false, and misleading claims, have stigmatized the whole subject in the eyes of many honest surgeons.

I think it is the part of wisdom to limit this discussion today to the factors in the technic of orthoptics, rather than risk embroilment in endless argument regarding its value and results. Less argument and more action seem to be indicated if we are to solve the problem of the best treatment for our squinting children, or even if we are merely to explain why there should be such a variance of opinion.

If a sufficient number of properly trained and emotionally capable ophthalmologists can be persuaded to devote sufficient time, energy, and emotion to carrying out comparable procedures, we will not long lack the answer to many of our problems.

I shall utilize the remainder of my time to supplement the instruction in the technic which Doctor Emerson has given us with a few additional factors we have found of value

PERSONALITIES

Doctor Emerson has indicated that patience, persistence, and sympathetic understanding are important. I consider the personalities of the trainer and patient of prime importance. No one should be doing orthoptics who has not an intense interest in and respect for children as personalities—who does not derive a real pleasure from their association. In no phase of ophthalmology is this mental-emotional transfer so important. More than any single factor it probably explains the gratifying results of such a person as Miss Maddox and the failure of others. Friendliness, spontaneously expressed, sympathy and intelligent imagination are essentials if the best results are to be achieved.

SELECTION OF PATIENTS

Assuming a properly qualified trainer, there must be a selection of patients made on the basis of type of squint and personality of the patient. We do not accept paralytic squints, patients with Duane's syndrome, or obvious retinal pathology, for treatment. Each patient is discussed before training begins, and is assigned to that trainer most likely to obtain and maintain coöperation. It is not infrequently advisable to change the patient from one instructor to another if personality difficulties arise.

PARENTS

The parent must be forced to accept and carry out certain responsibilities. The responsibilities

are simply expressed to her and definite, and no evasions or alibis are tolerated. During the preliminary work-up the case is discussed with the parent. It is explained that functional training is an educational process just as learning to play the piano is. It requires just as much, if not more, attention, coöperation, and practice. Responsibility for much of this must rest upon the parents. After the first visit the clinical secretary mails a questionnaire to the home. This serves as a check on the address (which may have been falsely given), and as the first objective reminder that the parent must actively coöperate. Patients are seen by appointment for which a definite period is reserved, and a mimeographed card is given defining the appointment.

VISION TESTING

Doctor Emerson does not mention what I believe is one of our most valuable contributions to technic,—that is, the system of obtaining a record of the child's visual acuity. This can be done with surprising accuracy in children as young as three years of age, and sometimes even younger. The material was developed by the *National Society for the Prevention of Blindness* from whom it may be obtained for thirty-five cents. Using this material the parents are required to keep an accurate record of the child's vision, and present it at each clinic visit.

One of the first tasks assigned to parents is to teach the child to count up to five. This is an interesting game, furnishing possibilities for much social contact with the child, and leading up to the use of the Worth four-dot test for fusion, which we find very valuable. The proper use of this simple and inexpensive test, particularly if various sized dots are used, furnishes a means of making part of our diagnosis almost as automatic as the Ishihara color test.

OCCLUSION

We differ from Doctor Emerson here in that we believe that, in the presence of amblyopia, occlusion should be constant and complete. We recognize the objections raised against this technic, but our experience has failed to validify these objections in the great majority of cases. Children are infinitely more adaptable than adults. School children whose vision in the poor eye is inadequate for their work may transfer the occluder to the squinting eye during school hours, but at no time should the two eyes be uncovered except in the periods of controlled training. Of major importance is the careful outlining of definite games, exercises, and work to be done in order to stimulate the function of the poorer eye. It cannot be assumed that simply because one eye is covered, the child is making efforts to improve the vision of the poor eye. The stimulus for these efforts must come from parent, physician, and trainer, and for this much imagination and inguenuity are required.

PROJECTION

We feel that any amount of uncontrolled training in the presence of false projection can only serve to confirm rather than cure the squint. Hence we would feel lost without the synoptophore or some similar instrument for determining the presence of true projection. It is on this basis that our cases are finally classified. I think it is the most important single point in the technic of orthoptics. Inattention to the state of projection, or retinal correspondence, true or false, which means, I am convinced, inattention to the habits already formed by the patient, will explain much of our failure to achieve results. False projection is present in a large percentage of the patients we see; and until it is overcome, there is danger that uncontrolled orthoptic trainnig may be accomplishing exactly the reverse of that for which we are striving. Unless Dr. Emerson has some objective means of discovering and controlling this factor, I am afraid he will meet with some serious and insurmountable difficulties.

STIMULATION OF THE AMBLYOPIC EYE

It is a great mistake and an invitation to failure to assume that, because the better eye is covered, the child is striving to improve the vision of his amblyopic eye. Such perfunctory treatment is the probable explanation of much dissatisfaction with results. An infant can hardly be expected to comprehend the reasons for depriving him of the use of his better eye,—if indeed, he is aware of the fact that he has a better eye. He may lack the knowledge that better vision than he has in the amblyopic eye is possible, certainly the knowledge as to how to go about improving it. In a world controlled by adults, much must be accepted on faith, and the child is likely passively to accept what he does not understand.

For these reasons it is important to encourage, aid, and stimulate him in every possible way to use the eye for closer and more critical observation. Sympathy, patience, and enthusiastic imagination are the greatest of assets in devising new games to play, new ways to stimulate the eye, new means of consolidating the gains made. It is in this field that some of the greatest advances in orthoptics have been made in recent years. To arrest the attention by color and motion, and then to control that motion by the patient's hand through his poor eye, is to combine two seemingly sound principles into a powerful means for attaining our end.

This discussion was opened with a quotation from Maddox. It may fittingly be closed with a final word of encouragement from the same source:

"The two essentials for squint training are perseverance and concentration. It makes a difference whether we knock at a front door softly or loudly, and sometimes we have to knock repeatedly, before it opens. It is so with the brain. Exercises may seem to have no effect for some time, and then suddenly succeed, the effect being cumulative, each one, though apparently disappointing, contributing to the final end."

Not the least part of my pleasure in being invited to speak before you comes from this opportunity to pay my sincere personal respect to a man who for more than thirty years has striven towards a splendid ideal. He hasn't achieved it—perhaps some of us who follow or those who follow us will

solve this fascinating problem—but the name, Linn Emerson, should be engraved among the American Pioneers in Orthoptics.

DR. SHIPMAN

I have been following the use of training for the past five years, and am very deeply interested in it. I know it has a future. I agree with Dr. Hardy when he says this should be controlled by the ophthalmologist. There are optometrists using it, and the main reason is because doctors may not have the patience and perseverence and personality. I have found a young lady well trained and under supervision makes a very excellent combination with the ophthalmologist to carry on this work. I have one coming in two days a week to care for children as well as adults. We must learn a great deal more about it, and will do a great deal of good with it as we learn.

DR. MARSH

I cannot add anything to the discussion but want to bring out the relation of optometrists. I do not think it is possible to take any action. The Optometry Act says, "Adaptation of lens by an objective and subjective, etc." This should be done under medical supervision. Probably the optometrist could be used as a technician.

DR. EMERSON'S CLOSING DISCUSSION

There is much more than could be gotten into a small paper.

The recommendations by Dr. Hardy are well taken.

I find that I cannot accomplish anything with certain patients by covering the other eye.

I have used atropine four or five years, and have several hundred cases where we started with a vision of 20/50-20/70 and even 20/100 and now they have 20/15.

I have been doing this work twenty-five years, and one reason I have succeeded is because I have done it all myself. I do not do any clinic work any more, but all in my office; and I do it all myself and get better results.

All the things being done with pictures and stereoscope I have pounded away at for years, and now I am gratified that all the men, Black, etc., etc., have used them. More patience and perseverence and technical skill are important. Many more than fifty per cent of these cases are cured by these methods.

VISUAL REQUIREMENTS FOR AUTOMOBILE DRIVERS

By Elbert S. Sherman, M.D., Newark, N. J.

Read before the Eye, Ear, Nose and Throat Section of The Medical Society of New Jersey at the Annual Meeting in Atlantic City, June 4, 1936.

In the last fifteen years—1920 to 1935—388,936 Americans were killed as a result of automobile accidents. In all the wars of our history—1776 to date—244,357 Americans were killed.

According to a recent statement based on reliable statistics, one of every twenty persons in the United States will, five years from today, have been more or less seriously injured in a traffic mishap, if the present automobile accident rate contines. The subject of this paper, selected by our Chairman, is therefore timely.

It is not my purpose to criticize our present standards or propose any material change. New Jersey is abreast of the times in its physical requirements of applicants for a license to operate motor vehicles. In fact, it is, and for several years has been, far ahead of most states. As recently as 1934 nine states required no driver's license, and in twenty others where a license was required, there was no visual test.

That some investigation should be made of an applicant's physical fitness before granting him a driver's license would seem to be no longer debatable. The only question is the nature and extent of the examination. It is self-evident that there are certain mental and physical disabilities which render anyone unfit to safely operate a motor vehicle. The disqualifying extent of other or lesser defects is not always easy to determine; and because physicians and others may differ widely in their opinions as to what constitutes physical fitness, it is necessary that standards be adopted of the minimum amount of efficiency below which it would be unsafe for the average individual to operate a car.

The licensing authority in this State is the Commissioner of Motor Vehicles. While the law says that the Commissioner in his discretion may refuse to grant a license to any person who shall in his estimation be an improper person to be granted such a license, he is somewhat restricted, in that the act further provides:

"No physical defect of the applicant shall debar him or her from receiving a license, unless it can be shown by common experience that such defect incapacitates him or her from safely operating a motor vehicle."

In 1927 Mr. William L. Dill, who was then Commissioner of Motor Vehicles, requested the aid of the State Medical Society in formulating some physical standards for applicants for driver's licenses. The suggestions as to visual requirements made at that time by a committee, of which the writer was chairman, were adopted substantially as offered, and have since been in use.

In New Jersey, during the years 1913 to 1935 inclusive, 2,264,689 individuals were examined by the Motor Vehicle Department concerning their fitness to be given a driver's license. Of these, 390,016 (about 13 per cent) were rejected. In recent years the percentage of rejections has been somewhat higher.

Visual tests were begun in 1927. During the past six years, 1929 to 1935, the number of applicants examined was 819,271, of which number 148,317 (16 per cent) were rejected. Of the rejections, 24,322 (16.4 per cent) were for visual defects. These figures indicate a highly commendable degree of diligence on the part of the inspectors.

The principal requirement is 20/50 acuity in one or both eyes, with or without glasses. Color vision is investigated as to the applicant's ability to interpret ordinary traffic lights. The visual field is not measured.

An applicant with an artificial eye, or with vision of 20/100 or less in the poorer eye—not improved with glasses—is given a conditional license endorsed "Impaired right eye—no glasses", ar "Impaired left eye—no glasses", as the case may be. If one eye is normal, and the vision of the other 20/65 and uncorrectable, no condition is imposed.

An applicant with vision below 20/50 in either or both eyes, which is correctable, is rejected until the correction is obtained; and is then given a conditional license endorsed "Must wear glasses while driving".

It is the policy of Mr. James J. Shanley, the Chief Inspector, to make the tests as simple, rational, and flexible as possible, consistent with denying the privilege of the highways to those who are physically and otherwise incompetent and dangerous. Opinions may differ as to the sufficiency of the above standards. For the careful, cautious driver they are undoubtedly adequate. Higher standards would be a hardship to many individuals with impaired vision who have safely operated cars for years without a mishap. I believe, however, that it would be advisable to limit those with vision poorer than 20/40, especially one-eyed drivers, to daylight driving. Those who are definitely color blind for red should be similarly restricted.

A few states have higher visual requirements than New Jersey. Delaware has the most exacting standard. It requires 20/20 in one eye, or 20/30 in the better eye, and 20/40 in the poorer. District of Columbia requires 20/40 with both eyes, and a visual field of 140 degrees. Ohio and Minnesota require a minimum of 20/40, the latter in each eye; and in both states one blind eye excludes. New York requires 20/40 in the better eye; Pennsylvania 20/70; Connecticut 20/70 in both, but if one eye is blind the other must have 20/50.

I know of no state which rejects because of color blindness. If such a regulation were made, approximately three per cent of male drivers would be denied a license. As a matter of experience, only an extremely small percentage of drivers are so color blind as to render them dangerous. They have means of compensating for the defect, particularly in daylight.

While a wide visual field is an important requirement for safe driving, there are practical reasons for not making its measurement a part of the routine examination. Field defects are usually either associated with ocular diseases which impair visual acuity, or with brain lesions which cause other obvious physical disability. However, one-eyed drivers should have an approximately normal field, or about 140 degrees in the horizontal arc.

As ophthalmologists, we should not make the common mistake of overstressing the importance of the organ in which we are most interested. Visual tests are important, but experience has shown that visual disability is a

rather rare cause of street and highway accidents, and that normal vision is no measure of a driver's ability to avoid accidents. It has been proved that accident-prone drivers have as good vision as good drivers. Besides adequate vision, alertness, good judgment and skill are important requisites of safe driving. What I am trying to emphasize was aptly stated by Maxwell Halsey, Traffic Engineer of the National Bureau of Casualty and Surety Underwriters, when he said:

"It is not merely the picture which the eye presents to the operator which counts, but what that picture means to the operator; what he knows should be done about it; and whether he is willing to do it. Thus the problem now becomes one of a combination of the eye, the human brain, and the hand. It is possible to test this so-called eye-hand coördination, but the usual eye examinations do not do it."

In his instructions to inspectors concerning tests for color blindness, Mr. Shanley has about the same idea. He says:

"In the last analysis, we are not so much concerned with what an applicant calls a color, as we are concerned that he knows what the color indicates that he should do."

CONCLUSIONS

It seems to be unnecessary, at present, to advocate any radical change in the standard visual requirements now effective in New Jersey. The suggestions made in this paper can be better evaluated by those whose official positions bring them in constant practical contact with driving hazards and their results, than by those of us whose views may be more or less theoretical. If and when there is any stiffening of the requirements, it should begin with the repeaters. In certain industrial plants a large percentage of the accidents are caused by a small percentage of the workers. The same is true of automobile accidents. Statistics from Connecticut indicate that 15 per cent of the drivers are responsible for 100 per cent of the accidents.

With the constantly increasing speed at which cars travel, it is becoming more necessary that some investigation be made of the *reaction time* of the motor vehicle operator, and of his ability to judge speed and distance.

The Motor Vehicle Department is apparently doing very effective work in rejecting applicants with the grosser visual defects. The visual disability of those who meet the requirements and are licensed is probably an exceedingly small factor in any accidents in which they may later become involved.

DISCUSSION

DR. H. L. HARLEY, ATLANTIC CITY

This has been a pet idea of mine for some time, rightly or wrongly; and I knew that Dr. Sherman was the man to present it. He has answered several of my questions satisfactorily. He says we must not stress the eye too much, as if it were the most important organ in the body, in the examination of auto drivers. If we were asked to pass on the many defects in auto drivers, we might involve ourselves in a lot of legal difficulty, court trials, and so on. I imagine all of you have had requests from patients, as I have, to give them certificates saying they are competent to drive, when it is not so.

I have recently had three men patients give up driving because they know they are not safe, and they thought they would quit before someone was seriously injured.

It seems to me that judging distance is a very important thing. I know that a patient whose eye I removed has a very bad time dodging safety islands.

I wonder if there is a practical reason why visual fields should not be taken? I understand that the visual requirement is 20/50, and I do not think that is quite high enough.

We have automobiles first; but automobile *laws* follow much later. I think it has been but a few years, about thirty, when engine drivers were tested for color vision. Now no one would ride behind a color-blind engineer. This was pushed by the American Ophthalmology Society twenty years ago. The story is fairly interesting. Out of 100 engineers tested six were found color blind when tested with colored yarns. They told the examiner they were not knitting, but driving strong engines. Railroad lanterns with colored globes were then introduced and the color-blind ones were rejected; and it was only then that the law became effective.

There are plenty of color-blind drivers who know traffic lights, not by their color, but by their position.

The statement was made that very few accidents are attributable to poor vision. We have the privilege of doubting that.

MR. JAMES J. SHANLEY, CHIEF INSPECTOR, DEPARTMENT OF MOTOR VEHICLES

In the first place, I would like to voice the appreciation of Mr. Magee and myself for the opportunity to be present this morning. It is nice to know that the Society is again delving into this

important problem of visual acuity of the auto driver.

I would like to give you briefly the set-up of our department. It will be thirty years old July first. In the beginning there was an inspection force of four men, three of whom were laid off in October, and one left on in the Winter, as there was not sufficient work for all four.

The force now consists of seventy men. We have required licenses in New Jersey for thirty years. In the beginning you would just make a statement that you could drive.

Examinations were started twenty-three years ago, and since that time we have examined 2,750,000 applicants, of whom 400,000 were rejected for various reasons.

The present system of eye examination was inaugurated March 1, 1927, after some conferences with your Society and other authorities on the part of Commissioner Dill as to just what the set-up should be.

Prior to that we made an attempt to test the visual acuity on the road test, and would ask the applicant to read a sign or license plate. On March 1, 1927, we began using a chart. Optometrists would appear at the examining point and were to work in shifts. This was all right for a time, but we have thirty-four different points, and soon some of them did not show up, and a few did all the work and were kept away from their regular practice.

In December, 1927, we took up the examinations ourselves. We average 2500 to 3000 rejections a year because of defective visual acuity which would be a bar to the safe operation of a motor vehicle.

This is a pretty broad subject, and we do not want to digress too far; but there are one or two pertinent remarks I want to make. We have lots to learn about this subject. Our requirements should be made more stringent; but from a practical point of view I think we can go too far too soon, because so many other states have no requirements at all, and if we make ours too stiff some of our citizens will assume residences in some of our weaker sister states and continue to ride in our state anyway under reciprocity and we are compelled to hold off as some states require not even drivers' licenses.

We are glad your Society is delving into this field; and if something practical can come out of this meeting this morning we will be only too glad to adopt your suggestions if we can.

I will be only too glad to answer any questions.

DR. HARLEY

I should like to ask Mr. Shanley a few questions. He says visual field examination is not practical. Why not?

The judgment of distance or stereoscopic vision seems important. A one-eyed man cannot judge distance. I have had a license since 1911, but no one has ever asked me if my eyesight continues good. Would it not be well to know?

Your inspectors reject a person, and that person comes to me. I find something which I can, from a medical standpoint, improve; but I cannot increase the visual acuity very much—as in the case of hole at the macula with no central vision, but very good peripheral vision, and I know him to be safe but your inspectors do not know it. I wonder if, when many of these people go back with glasses, how many are really any more fit to drive. You know you can go to the five-and-ten-cent store and get a pair of glasses.

Does Mr. Shanley think 20/50 vision a requirement high enough far safe driving?

DR. J. W. HURFF, NEWARK

I would like to ask a question. I believe you are no longer requiring a one-eyed driver to wear glasses. We all know the danger of a foreign body in an eye while driving; and in a person with only one good eye it would seem that glasses would be a protection against this. I am wondering why it has been discontinued.

MR. SHANLEY

With reference to the measuring of visual fields: On Memorial Day we examined 787 in seven hours; and so if you will give us some practical way to examine for this, we will do so.

Stereoscopic vision is very important; but again if we go into this we will be just so far ahead of the other states; and we are going to get up against some people who are lacking in ability; and we will black list them and they will circumvent our system some way.

The subject of reëxaminations has come up repeatedly at our conferences and others; and if we are to say that every three or five years our people must come up for reëxamination, we should be just so far ahead subjecting our people to something not required in other states. There is always the bugaboo of loose requirements in our sister states.

We have this in the set-up: that you must make a personal appearance to renew your driver's license. Do an over-the-counter business, and agents are instructed only to give renewals on personal appearance. We have about 150 agents around the State. They are quasi-political appointments, and not subject to the same discipline we are. Agents do catch quite a lot of people that have suffered from disability, loss of locomotion, eye accidents, and so on.

Recently we started to check up on accident repeaters. Other states started the same time we did. We are bringing these drivers in for a hearing; and if they have several accidents, we bring them to Trenton and try to see what causes them to be accident repeaters.

Unfortunately for about a year we have been without a deputy commissioner, and in our set-up this is the hearing commissioner. Now that a new one has been appointed, this will function again and we are considering taking these accident repeaters and going into their visual acuity to see if it is responsible.

We do not tell people to "Go get glasses". If I caught a man using that phraseology, it would be too bad for him. We tell them to go to their doctor, and we say "Doctor", and not optometrist, or optician. We at least hold them off and send them away. We cannot send them to a special place.

We try to keep the whole thing absolutely divorced from commercialism.

Many go to their family doctors, and then they come back to us with a certificate from him; and after seeing some of them, we know a little more about some of the doctors; and that is talking right out straight, but it is true; and then we have to send the drivers away again.

I was always a booster for the mechanical protection, using the same argument as Dr. Hurff did. In 1927 the windshields were not as good as today.

There is also a commercial tinge to mechanical protection, and it caused an awful lot of discussion. In many cases it did not help. Most complaints were made about the night driving when the reflection was bad, and so we went into it and after a thorough consideration of all angles, and because of the fact that almost nobody drives without a windshield, we discarded it about five years after we inaugurated it.

DR. C. W. BUVINGER, EAST ORANGE

I would like to ask Dr. Sherman how he arrived at 20/50; and would like to ask Mr. Shanley why he thinks that, if the requirements were raised in New Jersey, citizens would go to other states? In many other states, if you stay over two weeks, you must get a visiting license, as in Rhode Island. Why don't we do that in New Jersey? Or why, if we know he is a citizen of New Jersey, couldn't we prohibit him driving without a New Jersey license? Maybe a difference for visual acuity in cities and in open country sections is the reason we do not have this requirement. It should be higher in cities than in counties where traffic is not great. In some sections you can drive for half an hour or an hour without any need for increased requirements; but in cities such as Newark, Trenton, Atlantic City, and Camden, there should be higher requirements in the congestion.

Army requirements used to be 20/40 for one eye, and 20/100 for the other. A man was rejected if he could not measure up to that. I would like to ask Dr. Sherman how these figures were arrived at.

MR. SHANLEY

Out of 1,100,000 drivers, we have conservatviely 200,000 non-resident drivers; and next Sunday we will have 400,000,—all from states where there are no eye tests.

DR. JAMES W. SMITH

Does Dr. Sherman feel that, in the driver with only one good eye, the vision should be higher in the left as cars are made with left-hand drive?

In New York I notice on my renewal license on the reverse side there are six lines giving an opportunity to record if the holder has been in accidents, or arrested in traffic. It is not detachable and the officer knows that he has been in accidents and picked up in that way.

Does the Inspector feel that national and not State legislation is required so that states with no requirements would be taken care of?

MR. SHANLEY

National legislation is out. You are up against the state rights proposition, and I think a uniform set-up will come through an interest on the part of organizations like yours. Our conferences are held twice a year, and it is left to the administrator. If you cannot sell the legislature this year; you have to go back and try all over again next year.

The violations record on the New York license is not new. It has been tried in many states and discarded. We have considered it many times.

On reciprocity and why don't we catch these people: In Newark we have more cars than in the whole state of Rhode Island. Provisions up to 1931 called for ninety days for passenger cars, and fifteen days for trucks. New Jersey licenses were discriminated against when abroad. Mr. Hoffman caused a survey to be made, and he found that the greatest revenue any one year was $273,000; whereas it was costing our people $3,000,000, and so he had an act passed that made our friends set exactly reciprocal terms.

One of the sore points for the administrator is the question of residence. A person's residence is the vaguest sort of thing. Anyone can elect a residence anywhere. There are no requirements. You can say "I am a resident of Ohio"; and unless you nullify it by registering and voting and making it clear that you are a New Jersey resident, no one can dispute it.

DR. SHERMAN

I want to thank Chief Inspector Shanley for coming here and giving us this interesting and instructive discussion. As I tried to intimate in the paper, we can all theorize as to what we should do, but it is really men like Mr. Shanley who can best evaluate our suggestions.

Sixteen per cent of the rejections were because of visual defect; and the examinations are keeping a lot of people off the roads who should not be there.

I believe that all one-eyed applicants should have a visual field examination, and it is certainly advisable that all one-eyed individuals, whether driving a car or not, wear glasses for protection of the sound eye, irrespective of whether the vision is improved with the glasses.

As to why 20/50 was suggested: That was the suggestion made to The Medical Society of New Jersey in 1927 by the Sub-Committee of the Welfare Committee; and, as I recall it, after careful consideration of the report on visual requirements of the Section on Ophthalmology of the American Medical Association, which came out in 1924 recommending a similar requirement, we adopted it. We felt it could be modified later, but it does not seem practical to do it now.

I can hardly agree with Dr. Buvinger that better visual acuity is needed for city driving. It is on the country highways, where the speed of the car is usually much greater and the illumination at night is poor, that good vision is more important.

HEARING OF AUTOMOBILE DRIVERS

By Douglas Macfarlan, M.D., Philadelphia, Pa.

Read before the Section on the Eye, Ear, Nose and Throat, at the Annual Meeting of The Medical Society of New Jersey, on June 4, 1936, in Atlantic City.

It would appear that, for automobile driving, there could scarcely be two human capacities more important than sight and hearing. But, at present, there is no uniformity in the laws governing the licensing of drivers in the various states as to these capacities. Such regulations as exist are, in most instances, as applying to hearing requirements, in a hopelessly unintelligible tangle.

In Pennsylvania, the law is that no one lacking two per cent of normal hearing should be issued a license,—this was amended to permit such a person to drive if his machine was equipped with a mirror so located as to reflect a view of 200 feet (presumably to the rear). Now, what is two per cent of hearing loss? It is an insignificant loss. What is normal hearing loss? We have at present no set standard. With the amendment any or all deaf persons may drive.

In New Jersey, a most sensible situation exists as to licensing:

"The Commissioner of Motor Vehicles may in his discretion, refuse to grant a license to drive motor vehicles to any person, who shall, in the estimation of said Commissioner, be an improper person to be granted such a license. Provided, however, that no physical defect of the applicant shall debar him or her for receiving a license unless it can be shown by common experience that such defect incapacitates him or her from safely operating a motor vehicle."

It was a wise solon who drafted this law.

A communication or release of the Keystone Automobile Association of Philadelphia is interesting as to the present approach in Pennsylvania:

"Statistics of the Pennsylvania Department of Highways revealed that deaf drivers are the safest of all classes. There are 1700 deaf drivers in Pennsylvania as classified by the Department; and these of course include the hard of hearing. The procedure here in Pennsylvania is:

1. Apply for a learner's permit, good for sixty days, and state plainly that the person is *deaf*.
2. Take the examination.
3. If passed, the examiner reports to the Highway Department that the person is deaf.
4. The Highway Department then notifies the member of the Special Advisory Committee (here we have three members) of the district in which the applicant lives, and member reports back to the Highway Department whether or not that the applicant is a fit and proper person. If one member is in doubt, he may consult the other two members, and all report together.

"It takes men of some backbone and character to serve on this committee, otherwise there might be a temptation to graft and bribery. Our Highway Department keeps a special file of deaf operators. Our drivers' licenses have the word *deaf* typed after the name and address."

A communication from the Volta Bureau, the central organization for the deaf, is informative as stating the position taken by the deaf themselves:

"A resolution was presented to the American Medical Association and referred to the Reference Committee on Legislation and Public Relations.

"As public-spirited citizens, we could not fail to applaud the interest of physicians in curbing traffic accidents. We want to ask your consideration, however, on a point which appears to have been overlooked in the presentation of the resolution. It is contained in the passage which states, 'The damage to humanity may be curtailed by * * * stringent tests of * * * hearing * * *'

"Persons with normal hearing who have never given the matter any careful consideration almost always have the impression that normal hearing is necessary for safe driving. It is a well-established fact, however, that this is not the case, and we believe that grave injustice to the deaf and the hard of hearing may result if this resolution is adopted in its present form and published as the opinion of the American Medical Association. In a good many states legislation to prevent the deaf from driving automobiles has been projected at different times; but in every instance a real study of the actual facts has convnced the authorities that the deaf were not only equal to hearing persons in the safety of their driving, but in many instances, far superior. The Commissioner of Motor Vehicles in the City of Boston has repeatedly gone on record as stating that the deaf were freer from accidents than any other group of the driving public. This opinion has been echoed by authorities in other places, and has been expressed very emphatically by the Conference of Executives of Schools for the Deaf, a body of men with normal hearing who have had long and close association with the deaf and know their capabilities and limitations."

The fact remains that the deaf are really safe drivers. They are cautious and on the

alert, because they know the risk they are taking. This is more than we can say for the attitudes taken by most drivers with normal hearing. I, personally, had the common reaction that a deaf driver was bound to be a menace to others and a danger to himself. But time has changed my attitude.

How can all of this be explained? Deafness means often less distraction,—the back seat driver cannot disturb a deaf man; nor can squabbling children,—there is no interruption from casual conversation. The radio cannot be *"on"* to the deaf man.

The question of *vertigo* which often accompanies deafness is obviously a serious matter, causing a real driving handicap. I believe the one exception to danger for the deaf driver is the fire engine or ambulance that is allowed the right of way. Here, however, there are signs of alarm and attention from those hearing persons who are about. The deaf are quick at such observations. The proof of the pudding is in the eating. We quote Frank A. Godwin, Registrar of Motor Vehicles, Massachusetts.

"The best automobile law passed by the Legislature this year, and the law which will result in the saving of more lives than any other, is the law which now makes it unnecessary for an autoist to sound his horn or signal when arriving at an intersection of streets. This may sound strange and unusual, but experience in this office indicates that it is true, and here is the reason: In all of our experience since the Registry of Motor Vehicles was established, there has never been an accident case on record in which a deaf man has figured. Deaf persons are good risks, and if a deaf person indicates that he can handle a car our inspectors do not hesitate to issue a license. Our experience shows that a deaf person is extremely careful. A deaf man realizes his handicap, and he makes up for it admirably by keeping his eyes on the road, slowing down at street intersections, and he never takes any unnecessary risks. He realizes that the the other fellow may be sounding a signal, but he cannot be sure, so he takes the safest course and slows down. The new law places everyone in the position of the deaf man. It is not necessary now to sound a signal, and when an autoist arrives at an intersection, he is not sure that another may not be arriving on his right or left."

In closing, I would compliment your State on its sane law which seems inclusive and well drawn. I congratulate you on the honor, quality and efficiency of your state police, and upon the character of your justice. With such safe-guards, your driving for the deaf or for the hard of hearing is much less dangerous than in other states.

DISCUSSION

MR. SHANLEY, CHIEF INSPECTOR, DEPARTMENT OF MOTOR VEHICLES

For about six years we have been keeping very complete accident statistics. I think we have a fine division on the compiling of accident statistics, and we have never had enough trouble with deaf drivers to place them on the prohibitory list. They have a more thorough examination than the usual applicant, and receive a conditional license on which is noted *"deaf"* or as in many cases *"mute."* There is not much I can say pro or con on this subject. I do believe that deafness is a definite handicap to drivers, but I also believe it is compensated for by some of the things that Dr. MacFarlan mentioned.

DR. CASE

We have a slogan that there is a difference between *knowing* and *thinking;* and that is the secret of safe driving. Why don't deaf people have accidents? The answer is "I know before I proceed." The difference is between knowing, and thinking or believing; and this is the secret of safe driving.

DR. MacFARLAN

One thing may be of interest. In Pennsylvania we have a two per cent residual hearing law, and there is no method by which we may arrive at any percentage basis.

It is quite a pleasure to know that the American Standards Association has appointed a committee to standardize units of measurement of hearing, and the future records will be comparative. If we are called upon to state the percentage of hearing when it comes up in trials, we will be able to give something to the jury that will be intelligible to them.

OBSTETRICAL FEES

MATERNAL WELFARE—ARTICLE NUMBER FOURTEEN

By T. K. Graham, M.D., Paterson, N. J.

Today the modern doctor considers his obstetrical case as more than a delivery problem. He knows that the pregnant woman requires professional attention throughout her prenatal period, her labor and delivery, and for six weeks or longer postpartum. Why, therefore, should he charge a fee for each part of the treatment of this condition rather than a lump sum for the entire services required by the case? The psychological effect of separating the cost of prenatal and postnatal treatment from that of labor and delivery has an undesirable reaction on the patient. A woman often stays away from a prenatal appointment because she "feels all right" and is saving the office fee. A fairly high percentage of patients are not seen by the doctor till pregnancy is well advanced, or at term, either because of desire to reduce expenses, or from lack of understanding of the importance of such treatment. The doctor's problem is to get the pregnant woman to consult him early and then to keep her constant in her treatment till she is well on the road to recovery following her childbirth. Only in this way can he insure that the labor and delivery can be carried out with a minimum of danger and a maximum of safety.

Fees are a highly personal matter with each physician and naturally vary with the community in which he practices and the financial status of the individual patient. As a whole, obstetrical fees are lower proportionately than surgical fees. Little can be done to change this condition until public opinion and custom can be molded. A step forward will be accomplished by making the method of charging different from the piece-work basis of the general practitioner. Then the public will gradually come to think of pregnancy as a self-limiting state which requires a ten months' course of treatment. If there is a flat charge for the course of treatment, there is more likelihood that the treatment will be carried out in its entirety.

Several objections to the practice of charging a flat rate have been raised. Some of these arguments can be refuted. There is the case of a patient who is given antepartum care, and then changes her residence. This can be rectified when the situation arises by charging for the work that has been done, and by referring the patient to a doctor in the new location for subsequent care.

The difficulty in collecting a large lump sum might be considered as a stumbling block. However, many physicians will accept partial payments throughout pregnancy, and thereby lighten the financial burden at the time when hospital and doctor bills come due. Some physicians set terms such as one-third before a baby is delivered, one-third on leaving the hospital, and the balance at the postpartum visit. The amount of the fee and the method of payment must be adjusted to meet each patient's income.

At the present time it seems that the doctor charging a fixed fee for a maternity case is at a disadvantage because the patient compares his charge with that made by another physician for the delivery alone. Any change in custom has a tendency to cause an injustice temporarily, which will adjust itself in a short time. The gain to the doctor in knowing his patient well and understanding her condition when she comes to labor will greatly overbalance any small loss of fee he may experience during this transition period.

The principle of charging a fixed amount for the entire case should be acceptable to the patient, as it makes possible the planning of a very definite budget. It will also accentuate the need for antepartum and postpartum care in the minds of the public, and enable the medical profession to give the best possible care to maternity cases.

STATE SOCIETY ACTIVITIES

PRESIDENT'S ANNOUNCEMENT—No. 9

STATE MEDICINE

By Spencer T. Snedecor, M.D., Hackensack, N. J.

This series began in July, 1936

We still hear frequently the expression from doctors, "That's another step toward state medicine" or "Why this is state medicine." So we chose this subject as the title for our discussion this month in an effort to clarify in the minds of our members the position of the Medical Society in relation to so-called "state medicine".

We have been puzzling in our own minds for years as to what was meant by the term "state medicine". In a general way, it seems to denote the control and dictation of the practice of medicine and payment therefor by the government.

According to such a definition, we are now surely under the influence of "state medicine". But as we look back we can scarcely find a time when the profession was not to a more or less degree under the control of the state. In the matter of payment for the care of the indigent, we scanned the original constitution of The Medical Society of New Jersey and found that the doctors in 1766 expected the municipalities and counties to pay them for the care of their poor. Ever since then the practice of medicine to the poor has been at least in part "state medicine". Usually the "poor" doctor or city physician has been under salary to render medical care to this group.

Today we condemn this wholesale method of payment as "state medicine", and say that it is unfair both to the patient and doctor. Yet it has been acceptable practice for one hundred and fifty years. So, it does behoove us to carefully analyze our interpretation of objectionable features of so-called "state medicine" in the light of modern needs and practice.

Let us prescribe for our people the best method of modern medical practice, and hold to this tenet in all our contacts and associations with government agencies. Therefore, we say that insofar as economic and practical circumstances permit, the finest type of curative and preventive medical service can be rendered to the people by preserving the *personal* relationship between the doctor and patient, and permitting the patient to choose his physician. If we are consistent in this fundamental precept, then the ways and means of making contacts between the patient and the doctor, and arranging payment for services become secondary.

When the Emergency Relief agreement was put into effect we heard loud cries of "state medicine"; but actually, was that not a step away from the old undesirable method of city physicians or poor doctors on a salary? We believe that our Medical Relief Plan for medical care to the poor is sound.

When the plans of the Maternal Welfare Committee are discussed and the new objectives of the Venereal Disease group are brought forth, we again hear murmurs of "state medicine". The work of the field physicians is also called "state medicine". The various Public Health activities of the State Society are suggested as leading us into "state medicine".

Actually we do find that a benevolent government supported wholeheartedly by a charitable people is attempting to serve and save thousands of lives by better public health measures and better medical care of those in need. With this objective no one can quarrel. Furthermore, we do not as yet see but that this government is giving the physicians every opportunity to practice the better type of preventive service and curative medicine for his patients under conditions which are acceptable to him and assure him of a moderate income.

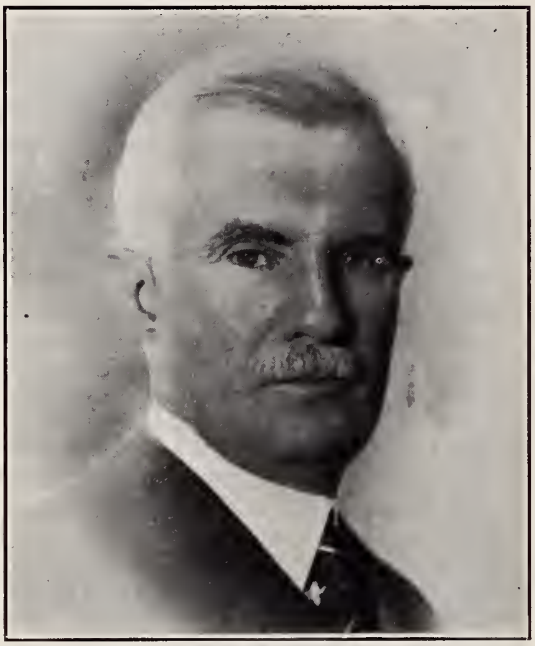
The modern challenge is not the antiquated shibboleth "state medicine" of putting all doctors on a salary, but who is to actually direct and control the distribution of public health and medical service? It is our belief that the medical profession is not only best fitted to lead in developing the better distribution of these services, such as the Social Security projects or the Emergency Relief plan, but can organize through its state and county units, to maintain reasonable supervision and control of such services.

As Dr. Kler, the Chairman of our Public Relations Committee, has pointed out, this is the age of group action. The organized medical profession, as a group, must plan and lead in the delivery of medical services of all types if *we are not to lose the control of medical practice,*—which is the true threat to be feared.

JOHN FRANCIS HAGERTY, M.D.

Born—May 9, 1869
Died—February 1, 1937

"His life was gentle, and the elements
So mix'd in him that Nature might stand up
And say to all the world,
'This was a man!'"



JOHN F. HAGERTY, M.D.

The passing of an individual is usually a casual or a local happening: A sermon, a hymn, a prayer, a sob, and then—silence. In the history of Medicine in the State of New Jersey there has been no event which has more thoroughly stirred the emotions of our colleagues than the sudden demise of our fellow practitioner, John Francis Hagerty.

A survey of Dr. Hagerty's life from his humble beginnings—his early education in New Brunswick, where he began his study of medicine in the office of Dr. Frank M. Donohue, graduating from New York University Medical College in 1892, and his subsequent career—mark him as the highest type of individual in all the protean attainments of which a man is capable. In a contemplation of his life work, there seems an element of the paradoxical. Himself a man of the greatest humility at all times, yet when called upon in any exigency in his profession, in cultural activities, in his church, in civic life, and in all types of leadership, he rose to the occasion with never an aggressive pretense at seeking honors.

His honory degree of LL.D. at Seton Hall College, his honors from Rome as Knight Commander in the Order of St. Gregory, and his honors in the various medical societies, all indicate the broad scope of his labors.

It was the intrinsic value of his virtues that compelled the recognition of his talents. Thus, it came to pass that he was chosen as the leader of our Essex County Medical Society and thereafter of our State Society. He was Medical Director and Attending Surgeon to St. Michael's Hospital, Newark, N. J.; Attending Surgeon, Hospital and Home for Crippled Children, Newark, N. J.; Consulting Surgeon, Presbyterian Hospital, Newark, N. J.; St. Peter's General Hospital, New Brunswick, N. J.; St. Vincent's Nursery and Babies' Hospital, Montclair, N. J.; ex-President, Academy of Medicine of Northern New Jersey, Essex County Medical Society, Society of Surgeons of New Jersey, Bellevue Hospital Alumni Association; a Fellow of the American College of Surgeons; Fellow and New Jersey Delegate of the American Medical Association; Regent of International College of Surgeons; President, High Point Park Commission; Army Captain in the World War.

In addition to the multiplicity of honors that were bestowed upon him, he was a surgeon internationally known for his work on goiter, a philanthropist, a devoted and splendid citizen. He will be remembered as a florid speaker—noted for his vision, and for his sturdy ability in debate which usually carried everything before him. He was also an ardent musician, playing the violin, and possessed a lyric tenor voice; an ardent golfer (was a member of the Essex County Country Club, and the Newark Athletic Club) and a swimmer.

To summarize, we may use that all-embracing word—*character*—of which he was the embodiment, as was shown by the affection and respect in which he was held and which was so well demonstrated by the outpouring of people from many walks of life at the funeral services. There were present tbout 100 clergymen, standing high in the ranks of the Catholic faith, to show the honor in which he was held among them; a large group of the Sisters of Charity, who had been the recipients of his devotion; about 150 physicians from different parts of the State, representing the flower of our profession; all of whom—in addition to his large family, to whom he left many bequests—would have filled a church again as large as St. Patrick's Cathedral, where the services were held.

HARRY B. EPSTEIN, M.D.

SCIENTIFIC PROGRAM OF THE ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

HADDON HALL, ATLANTIC CITY, N. J., APRIL 27, 28 AND 29, 1937

GENERAL SCIENTIFIC SESSIONS

Tuesday, April 27th, 1937

2:30 P. M.

1. Indications for Splenectomy (Lantern)
William P. Thompson, M.D., New York City
Associate in Medicine, College of Physicians and Surgeons, Assistant Physician, Presbyterian Hospital.

3:00 P. M.

2. Results of Splenectomy in Some One Hundred Cases of Various Types of Splenopathy (Lantern)
Allen O. Whipple, M.D., New York City,
Valentine Mott Professor of Surgery, Columbia University.

3.30 P. M.

3. Medical Aspects of Coma (Lantern)
William Hall Lewis, Jr., M.D., New York City
Assistant Clinical Professor of Medicine, New York University College of Medicine
Assistant Attending Physician, Bellevue Hospital.

4:00 P. M.

4. The Surgical Management of Coma,
J. Arthur MacLean, M.D., New York City
Surgical Service, Psychiatric Division, Bellevue Hospital.

4:30 P. M.

5. Selection of Treatment for the Tuberculous Patient.
J. Burns Amberson, Jr., M.D., New York City
Professor of Clinical Medicine, College of Physicians and Surgeons, Columbia University, and New York University College of Medicine.

5:00 P. M.

6. Adrian V. S. Lambert, M.D., New York City

5:30 P. M.

7. Electrosurgical Aseptic Intestinal Anastomosis (Lantern)
Victor Carabba, M.D., New York City
Assistant Clinical Professor of Surgery, New York University College of Medicine
Assistant Visiting Surgeon, Bellevue Hospital.

Thursday, April 29th, 1937

9:30 A. M.

1. The Treatment of Pituitary and Ovarian Disfunction
Rita S. Finkler, M.D., Newark
Adjunct Gynecologist, Endocrine Clinic, Newark Beth Israel Hospital.
Milton Friedman, M.D., Newark
Associate Roentgenologist, Radiation Therapy, Newark Beth Israel Hospital.

10:00 A. M.

2. Again,—Maternal Mortality Problems
Frederick C. Holden, M.D., New York City
Professor Emeritus of Obstetrics and Gynecology, New York University College of Medicine

10:30 A. M.

3. Failures After Gastro-jejunostomy—A Clinical and Experimental Study (Lantern)
W. Howard Barber, M.D., New York City
Clinical Professor of Surgery, New York University College of Medicine.
Anthony Bogatko, M.D., New York City
Assistant Clinical Professor of Surgery, New York University College of Medicine

11:00 A. M.

4. Oyxgen Therapy by Oro-pharyngeal Insufflation (Motion Pictures)
E. A. Rovenstine, M.D., New York City
Assistant Professor of Surgery (Anesthesia), New York University College of Medicine
Director of Anesthesia, Bellevue Hospital

11:30 A. M.

5. Management of Ureteral Calculus
Stanley R. Woodruff, M.D., Jersey City
Urologist, Bayonne Hospital and Christ Hospital, Jersey City.

12:00 A. M.

6. Hugh Young, Baltimore

GENERAL PUBLIC HEALTH SESSION

Tuesday Evening, April 27th, 1937

8:00 P. M.
Charles Gordon Heyd, M.D., President of the American Medical Association.

8:30 P. M.
Thomas Parran, M.D., Surgeon General, United State Public Health Service.

9:00 P. M.
Howard W. Haggard, M.D., Yale University.

SECTION ON RADIOLOGY

Wednesday Morning, April 20th, 1937

9:30 A. M.

1. The Treatment of Infections by X-ray
   C. F. Baker, M.D., Newark
   W. J. Marquis, M.D., Newark

10:00 A. M.

2. The Principles of the Coutard Technique
   Milton Friedman, M.D., Newark

10:30 A. M.

3. The Care of the Cancer Patient
   Elwood E. Downs, M.D., Woodbury
   Hoke Wammock, M.D., Philadelphia
   Ralph T. Artman, M.D., Philadelphia

11:00 A. M.

4. The Treatment of Lung Abscess by Means of Guaiacol Intravenously
   Charles H. Nammack, M.D., New York City

11:30 A. M.

5. The Value of Colloidal Thorium in Radiological Practice
   Ralph Pomeranz, M.D., Newark

12:00 A. M.

6. A Roentgen Survey of the Colon
   N. J. Furst, M. D., Newark
   L. J. Gelber, M.D., Newark

12:30 P. M.

7. Subdiaphragmatic Abscess
   W. W. Naver, M.D., Jersey City
   Charles Oderr, M.D., Jersey City

SECTION ON GASTRO-ENTEROLOGY

Wednesday Morning, April 20th, 1937

9:30 A. M.

1. Clinical Manifestations of Ingestion Allergy
   Joseph D. Goldstein, M.D., Jersey City
   Discussors: Hyman Goldstein, M.D., Camden; Dean Marquis, M.D., East Orange

10:00 A. M.

2. The Pathology of Intestinal Amebiasis
   Thomas T. Mackie, M.D., New York City
   Discussor: Manfred Kraemer, M.D., Newark

10:30 A. M.

3. Certain Aspects of Peptic Ulcer
   John L. Kantor, M.D., New York City
   Discussor: Sigurd Johnsen, M.D., Passaic

11:00 A. M.

4. Ulcerative Entero-colitis in Tuberculosis
   George G. Ornstein, M.D., New York City
   Emil Granet, M.D., New York City
   Discussor: Abraham E. Jaffin, M.D., Jersey City

11:30 A. M.

5. Tuberculosis of Ano-rectal Region
   Julius Gerendasy, M.D., Elizabeth
   Discussor: Carroll D. Smith, M.D., Paterson

SECTION ON EYE, EAR, NOSE, AND THROAT

Wednesday Morning, April 28th, 1937

9:30 A. M.

1. Nose and Throat Infections as a Cause of Ocular Disease
   E. Clarence Kern, M.D., Montclair
   Discussion

10:00 A. M.

2. Advances in Vernal Conjunctivitis (Colored Motion Pictures)
   Louis Lehrfeld, M.D., Philadelphia
   Discussion

10:30 A. M.

3. Uveal Tuberculosis
   George P. Meyer, M.D., Camden
   Discussion

11:00 A. M.

4. Do We Operate Our Refractive Department Gainfully
   W. G. Hayden, M.D., Toms River
   Discussion

Thursday Afternoon, April 29th, 1937

2:30 P. M.

1. Plastic Repair an Aid in Therapeutic Nasal Surgery
   Alfred M. Mamlet, M.D., Newark
   Discussion opened by: Prof. Kurt Engelmann, Berlin.
   General Discussion

3:15 P. M.

2. Malignant Tumors of the Upper Air Passages
   Edward A. Atwood, M.D., Paterson
   Discussion opened by: Henry B. Orton, Newark
   General Discussion

4:00 P. M.

3. Election of Officers

SECTION ON PEDIATRICS

Thursday Afternoon, April 29th, 1937

2:30 P. M.

1. The Relation of Orthodontia to Pediatrics
   Ralph Waldron, D.D.S., Newark

3:00 P. M.

2. The School Physician
   Harry B. Silver, M.D., Newark

3:30 P. M.

3. Conduct Disorders
   Leslie E. Hohman, M.D., Baltimore

4:00 P. M.

4. The New Born
   Robert Wright, M.D., East Orange

SCIENTIFIC EXHIBITS AT THE ANNUAL MEETING, 1936

ARTICLE NUMBER FOUR

By Asher Yaguda, M.D., Newark, N. J.
Chairman, Committee on Scientific Exhibits

RESPIRATORY DISEASES

Abraham E. Jaffin, M.D., Jersey City



Photograph Number 13.—Clinical Roentgen Studies of Diseases and Other Affections of the Respiratory Tract. By Dr. Abraham E. Jaffin, Jersey City, N. J.

The purpose of the exhibit, entitled *Clinical Roentgen Studies of Diseases and Other Affections of the Respiratory Tract,* presented at the 1936 Annual Meeting, was to demonstrate the unique value of roentgen studies of various parts of the respiratory system in differential diagnosis.

Series of cases were shown illustrating as many examples as possible of involvement of various organs and structures connected with the function of breathing. Among these were:

Thyroid Diseases (involving the trachea by pressure):

1. Substernal enlargement
2. Tumors
3. Calcification

Tracheobronchial Adenopathy:

1. Tuberculosis (various forms)
2. Hodgkin's disease

Bronchial:

1. Bronchiectasis
2. Foreign bodies
3. Tumors
   a. Benign
   b. Malignant

Lungs:

1. Tuberculosis
   a. Childhood type
   b. Basal tuberculosis
   c. Miliary tuberculosis
      (1) Acute
      (2) Chronic
   d. Complications
   e. Oleomaintenance compression
2. Lung abscess
3. Lung tumor
   a. Primary
   b. Metastatic
4. Lung cyst
   a. Congenital
   b. Bullous emphysema
5. Dust diseases
   a. Silicosis
   b. Asbestosis
6. Atelectasis
7. Fungus disease
   a. Moniliasis
8. Pneumothorax, spontaneous

Pleura:

1. Azygos lobe
2. Interlobar pleurisy

Diaphragm:

1. Traumatic evisceration
2. Eventration
3. Atony
   a. Traumatic
   b. Secondary to malignant invasion of "phreni"

The importance of serial films in the course of intrathoracic disease in revealing diagnostic changes is to be noted.

The value of complete lateral views in localization, especially for surgical approach, is also apparent.

NORMAL HEARTS BY X-RAY

The Prudential Insurance Company



Photograph Number 17.—X-Ray Variations in Size and Contour of Normal Hearts. By Dr. L. S. Ylvisaker and Dr. H. B. Kirkland, Newark, N. J.

The exhibit of the Medical Department of the Prudential Insurance Company emphasized the variations in the size, contour and position of normal hearts studied by means of x-ray films. Over 8000 individuals, between fifteen and sixty-five years of age, predominantly healthy applicants for insurance and employment, were x-rayed with an exacting technic calculated to reduce errors to a minimum. Estimations of size were made according to the Hodges-Eyster tables, the latter being accepted at present as the most practical for insurance purposes.

Individuals showing any deviation from normal by x-ray were subjected to thorough clinical, fluoroscopic and electrocardiographic examinations to rule out cardiac disease, and in many cases repeated observations over a period of years were carried out.

X-rays were shown in which hearts varied from 8 to 16 cm. in transverse diameter, from 27 to 59 per cent of the thoracic diameter, and from 30 per cent below to 23 per cent above the Hodges-Eyster predicted normal. In individual cases the variation in size and shape due to respiration reached 33 per cent, and a difference of 1 to 2 cm. in two stereoscopic films made under identical conditions was seen. Prominent left and right borders and hearts centrally or eccentrically placed due to other chest abnormalities were shown, as well as variations in the shape and diameter of aortic shadows under different conditions. As a contrast, examples of normal cardiac x-rays with known disease were available.

The exhibit was designed to stress the necessity of caution in diagnosing cardiac abnormalities on the basis of x-rays alone, and to show that such x-ray findings should serve only to direct further analysis of the heart condition.

NOMINATING COMMITTEE OF THE STATE MEDICAL SOCIETY, 1937

Chairman, Marcus W. Newcomb, Past President

	Member	Alternate
ATLANTIC	Scanlan, D. Ward	None
BERGEN	Liva, Arcangelo	Alexander, Samuel
BURLINGTON	Haines, Edgar J.	Hornberger, J. H.
CAMDEN	Lee, Thomas B.	Wilson, L. R.
CAPE MAY	Way, Clarence W.	None
CUMBERLAND	Miller, H. G.	Myatt, L. E.
ESSEX	Stahl, Alfred	Mount, Walter B.
GLOUCESTER	Downs, Elwood E.	Pedrick, William
HUDSON	Londrigan, Jos. F.	McLoughlin, Frank J.
HUNTERDON	English, S. B.	Coleman, A. H.
MERCER	North, Harry R.	Haggerty, D. L.
MIDDLESEX	Mann, J. J.	Haywood, H.
MONMOUTH	Maher, John E.	Clayton, John C.
MORRIS	McMahon, Bernard C.	None
OCEAN	Herbener, Eugene	Bunnell, F.
PASSAIC	Bergin, Joseph	To be elected in April
SALEM	Green, D. W.	None
SOMERSET	Renner, D. S.	Hegeman, R. F.
SUSSEX	Coleman, J. G.	Johnson, George
UNION	Morris, Watson B.	Murphy, H. S.
WARREN	Curtis, Frank W.	Skinner, William F.

WELFARE COMMITTEE

A meeting of the Welfare Committee was held on Sunday, February 28th, at 2:15 p. m., in the Stacy-Trent Hotel, Trenton, N. J., with the Chairman, Dr. Hilton S. Read, presiding, and the followings members present: Drs. Read, Shivers, S. Alexander, Wilson, Lewis, Sharp, Dandois, Sewall, Levy, Areson, Fort, Zehnder, Cardwell, Knight, Ulmer, Pollak, Schuck, Haggerty, Mann, Kler, Clayton, Sherman, Herbener, MacMillan, Ash, Field, Spencer, Weigel, Schlichter, Murphy, Varney, Snedecor, Morrison, Mahaffey, Fischelis, McGuire, Herrman, Morris, North, Carrington, Burritt, Brown, Sica, Lippincott, Satchwell, Lee, Evans, Irwin, Walker, H. Spence, Rowland, Sandella, Avery, Von Dielen, Truas, Armstrong, D'Arcy, and Wilkes, Secretary.

PATERNITY BLOOD TESTS

Dr. Philip Levine, Pathologist to the Beth Israel Hospital, Newark, gave a brief outline of the Bill A-359 for the authorization of blood tests by courts in cases in which illegitimacy is an issue, as has been done by the Legislatures of New York and Wisconsin. (See page 162 of this Journal.)

The bill has the official sanction of the A. M. A. Prominent lawyers in New Jersey have been consulted and they agree that it does not violate the spirit of the New Jersey Constitution. Dr. Levine requests the support of the Medical Society for the passage of this bill in New Jersey. This bill is now in the Public Health Committee of the Assembly.

The Welfare Committee endorsed the bill.

NURSING AND NURSING EDUCATION

The Committee on Nursing and Nursing Education presented a comprehensive report, which will be it annual report to the House of Delegates. The full report will be printed in the April Journal.

THE PURE FOOD AND DRUG ACT

Dr. Thomas K. Lewis, Chairman of a special committee of the Welfare Committee, reported on the proposed amendments to the Wiley Act, and commented favorably on the suggestions and investigations made by Dr. N. W. Burritt, of Summit. The committee submitted the following recommendations:

1. That The Medical Society of New Jersey unrelentingly fight for the preservation of the Wiley Act for the reason that it contains a mandatory clause, whereas the two proposed substitute bills leave prosecution to the discretion of a small group; and because the Wiley Act has functioned and does function.

2. That The Medical Society of New Jersey endorse and cause to be introduced the amendments as drawn up by Dr. Burritt.

3. That the Medical Society memorialize these amendments to the American Medical Association, and to every component State Society in the United States.

4. That the League of Women Voters, Parent-Teacher Associations, and other interested groups be contacted and be requested to support the aforesaid amendments.

5. That these proposed actions be promptly and vigorously prosecuted.

President Snedecor reported that Senator Moore had been informed of the attitude of The Medical Society of New Jersey and had promised to hold the bill in committee until the Medical Society could formulate its recommendations.

Dr. Mahaffey read a resolution passed at a meeting of the Sanitary and Medical Officers, asking Congress to strengthen the provisions of the present Wiley Act.

Dr. MacMillan moved that the steps taken by the State Society in relation to this bill be approved; that copies of this material be sent to the A. M. A.; that it be referred to the Public Relations Committee for proper interpretation to other organizations. Dr. Zehnder seconded the motion and it was unanimously carried.

The Welfare Committee adopted the following resolution:

"The Welfare Committee of The Medical Society of New Jersey wishes to express its sincere appreciation of the earnest and constructive thought provided by Dr. Norman W. Burritt on the Food and Drug Bills in the interest of the medical profession."

The Secretary was instructed to forward a copy of this resolution to Dr. Burritt.

TUBERCULOSIS SURVEY

Dr. P. S. Avery, New Brunswick, Secretary of the New Jersey Radiological Society, presented a plan of his Society for a tuberculosis survey of the state based on the plan adopted in Middlesex County. No action was taken.

MEDICAL RELIEF OF THE INDIGENT

The Chairman of this Committee, Dr. Schlichter, announced that his committee has conferred with Mr. Mudd and Mr. McCrossen, and they agreed to accept the old E. R. A. agreement with a few minor changes. Any

community accepting relief money from the R. F. C. of the State must accept also the E. R. A. plan for medical relief of indigent cases.

LEGISLATION

Dr. B. S. Pollak, Chairman of the Committee on Legislation, reported on a proposal to introduce the Medical Practice Bill that had been drafted by the Uniform Medical Practice Act Committee at a favorable opportunity.

Dr. Pollak also reported on bills now pending in the Legislature. (See Legislative Bulletins, page 195 of this Journal.)

MEDICAL PRACTICE

Dr. T. K. Lewis, Chairman of the Sub-Committee on Medical Practice, reported that the Advisory Committees were working on the details of their several problems, and were still in the midst of their investigations, but would give a summary at the Annual Meeting.

HOSPITAL RELATIONSHIPS

Dr. T. K. Lewis, Chairman of the Committee on Hospital Relationships, presented the report which his committee will give to the House of Delegates. It will be printed in the April Journal.

The Welfare Committee considered the budget of expenses for next year, and asked for more details of some of the proposals.

Dr. Herrman, President-Elect, announced his intention to continue the personnel of the Welfare Committee and its several subordinate committees, so far as possible, in order that they may develop the work which they have effectively begun.

LeRoy A. Wilkes, M.D.,
Secretary.

CONTRACT PRACTICE, MEETING OF COMMITTEE

A meeting of the Advisory Committee on Contract Practice was held on Sunday, January 31st, 1937, at 2:30 p. m., in the Executive Offices, 137 East State Street, Trenton. Those present were: Dr. Sharp, Chairman; Drs. Sica, Herold, Markley, and Wilkes.

Dr. Sharp announced the three general points for the Committee on Contract Practice to cover this year are:

1. Approximate number of men engaged in some form of contract practice.

2. Are these contracts in general meeting the requirements put forth by the A. M. A.?

3. Leaving out the question of whether they conform to the A. M. A. rules, are they satisfactory to the medical men in that particular locality?

Suggestions received from Dr. Snedecor were that the study be made on a fact-finding basis, and cover:

1. What are the definite types of contracts entered into by the doctors?

2. What facts can be discovered by gathering data on each type of contract practice?

No attempt should be made this year to set up standards. We should attempt just to draw a general picture of the conditions in the State, and work toward our own set of standards governing acceptable contracts.

A communication from Dr. Fort, Chairman of the Advisory Committee on Workmen's Compensation, set forth the objectives of his committee which will necessarily overlap the work of this committee somewhat.

1. Are the medical provisions of the law being enforced?

2. What are the defects of the present law from the medical standpoint?

3. What suggestions have you to offer to remedy points 1 and 2?

This committee is more particularly interested in:

1. Right of free choice of physician by the injured.

2. Provision of a medical referee for medical questions.

3. "Bill adjustment" committee to be legalized.

4. Plans for payment of medical bills by employees, and by insurance companies.

5. State medical employees working for insurance companies.

Dr. Sharp read Chapter III, Article VI, Section 2, of the A. M. A. Principles of Medical Ethics, page 106, A. M. A. Bulletin, May, 1936. It was felt that number five of the third paragraph was the most common form of contract practice which is most objectionable—"When free choice of physician is prevented".

This section is about 300 words in length, and cites the following features as unethical:

1. Solicitation of patients.
2. Under-bidding.
3. Inadequate pay.
4. Interference with competition.
5. Free choice of physicians prevented.
6. Burdensome conditions of employment.
7. Contrary to sound public policy.

Each member cited cases of contract practice as they exist in his part of the State. Dr. Sharp stated that this year the facts will be presented *as they exist;* and from this study we will eventually work towards what is considered by the State as an *ethical* contract.

The general concensus of the meeting was that this subject must be covered county by county with a questionnaire to individual physicians, to determine whether he is receiving compensation from any industrial concern or beneficial society for medical services. The question as to how far we should consider this remuneration as "contracts" is to be taken up at a later date.

MATERNAL WELFARE ADVISORY COMMITTEE

A meeting of the Advisory Committee on *Maternal Welfare* to the Sub-Committee on Public Health of the Welfare Committee of The Medical Society of New Jersey was held with the Field Physicians and County Maternal Welfare Committees Thursday, January 21st, 1937, 4:00 p. m., Essex House, Newark, N. J.

Dr. Arthur W. Bingham, Chairman, presided. Those present were: Drs. Bingham, Levy, Harman, Brown, Bacon, Hancock, Donnelly, Ely, Burnham, Hayes, Lawton, Kreutz, Hilliard, Graham, Crieve, Earp, Edwards, Geary, Weres, Davis, Purcell, Fahrenbruch, Underwood, Bowersox, Hessert, Gulick, Carl Ill, Heatley, Mount, Lyons, Gershenfeld, Marvin, Seidman, Edward J. Ill, Cosgrove, Edgar A. Ill, Pattyson, Bigelow, Frost, von Deilen, H. B. Wilson, J. H. Wilson, Bensley, Snedecor, Hallett, MacKenzie, Wilkes.

Dr. Bingham reviewed the program of the Maternal Welfare Committee for the year.

1. *Education of Profession for Prenatal Care in Physician's Office.*—We want all work to be done in the physician's office. We recommend that each physician use the prenatal history card, which will improve the work at least ten per cent. Prenatal centers will not be established in any county unless we are specifically requested for such a center by the county society.

2. *Isolation of Maternity Departments.*—This has been the suggestion of your committee for the past five years; now we need action on it. This is an important aim—to have a separate maternity wing, and if this is not possible, to at least have the maternity department on a separate floor.

3. *More Open Hospitals.*—We need more open hospitals where general practitioners may bring their patients. This should be stressed a little more; and if a doctor is doing good work, he should be extended the "open hospital" facilities.

4. *Maternal Welfare Conferences in Counties.*—The committee suggests that counties or districts hold maternal welfare conferences where doctors may meet and talk freely, and learn of different types of cases met by different men. This will be valuable education especially to the younger doctors.

5. *Free Nursing Delivery Service for the Low-Wage Group of Patients.*—The free nursing delivery service has attended 320 cases. The doctor is privileged to have this free service, and the nurse is paid by the State.

6. *Free Consultation Service.*—The doctor is allowed to call in any competent man he wants for this consultation service. Since May there have been only forty-seven cases for whom consultants had been called. The reason for this low number may be that the case is sent to the hospital as soon as complications set in. On the whole, the outlying districts have used this service.

7. *Consultation Service for Midwives.*—The committee has decided that to pick out men to consult with midwives is a difficult problem; and so the midwives will have the choice of consultant. We believe they will choose wisely.

8. *Lecture Courses.*—These courses will not be given this year. The pediatric courses will be given in the Spring.

9. *Refresher Courses.*—Arrangements have been made with the Margaret Hague Maternity Hospital in Jersey City for physicians to go there for a week, free of charge, or longer for a nominal charge; and take advantage of seeing all that goes on in this large hospital. It is a great opportunity for men in outlying districts to go there for a week or longer and observe modern obstetrical procedures. They have an average of 100 deliveries per week.

10. *Maternal Welfare Page in Journal.*—Each month we try to print some up-to-date article on some subject of interest to obstetricians. The committee will be glad to receive copy from anyone.

11. *Investigation of Deaths.*—The investigation of maternal deaths has just begun, and we have found many interesting things. We

have found that some are not really maternal deaths. The death certificates have been filled out by someone who has put down the contributory cause as pregnancy. We have checked on two, and have had the death certificates revised.

This brought up the point of internes signing death certificates. The committee thinks it a good idea for each county to follow Essex in making the recommendation that each hospital make it a rule that no interne shall sign a death certificate without the approval of the attending physician.

Maternal Mortality in New Jersey has been gradually improving since this committee went to work nearly six years ago. In 1930 the maternal mortality rate per 1000 live births was 5-9/10, in 1935 it was 4-5/10, and in 1936 it was 3-7/10.

12. *New Death Certificate.*—The committee suggests that if any change is to be made in the death certificate, in maternal deaths the following questions be added:

1. Was condition present before pregnancy took place?
2. Was pregnancy a factor in this death?
3. Month of gestation?
4. Date of birth of baby?
5. In cases of abortion—give date abortion occurred.

13. *Reports of Field Physicians.*—The field physicians present reported for their various districts. Each stated that the doctors visited were favorably impressed with the State Society plans and the work of the State Board of Health. The doctors seemed to favor the idea of early consultation, and many promised to use the free nursing service. They were very cordial in their reception of the field physician and are interested in Maternal Welfare Work.

Some few doctors brought up the question of *State Medicine,* and asked if this work was not leaning toward that. The reactions to the prenatal history cards was favorable from those visited.

Dr. Frost discussed the reporting of *septic abortions as maternal deaths.* Dr. Bingham replied that the Committee hoped to take this up with the State Board of Health and get it to classify the cases of maternal deaths.

(1) True obstetric deaths.
(2) Deaths from abortions.
(3) Deaths due to medical causes.

This really should be standardized throughout the country.

PRESIDENT'S ADDRESS

Dr. Bingham called upon President Snedecor to speak. Dr. Snedecor stated that from the point of the Medical Society it is believed that the maternal welfare plans and program and work this year is really the spearhead to deliver better medical services to the people. Some claim we are trying to promote State Medicine, but we are merely trying to promote organized effort by the profession for organized delivery of medical services. There is a great difference between this and the delivery of such services by the government. The Maternal Welfare program should be publicized through our county bulletins, by timely articles by field physicians, and by repeated announcements. This should be made known to the public.

The national objective is to study maternal health to see how it can be improved. A better understanding of this program should be passed on to public groups.

As to the work of the field physicians there is room for improvement. This is not a complaint against any individual, but on the whole the work is not as good as it could be. These physicians should realize that they are responsible to the State Department of Health, and the State Society must see that each man does his work well so that the work may be continued. This is called to your attention now because at some future date there must be a check-up. Perhaps it will be at the annual meeting, or when you come up for reappointment or reapproval. The State Officers are proud of Dr. Bingham and his Committee and their work.

A general discussion followed with reports by members of county societies represented.

It was the general concensus of opinion that:

1. All Maternal Welfare articles for publication should be approved by the State Committee prior to publication.

2. State Rules for Obstetrical Cases should be adopted by each hospital, and should pertain to the regular and the courtesy staff physicians.

3. Symposiums on Obstetrics or Conferences should be held in the counties or districts, rather than the lecture courses as given last year.

LEGISLATIVE BULLETIN NO. 1

Bulletin No. 1, issued by the Committee on Legislation of The Medical Society of New Jersey, was issued on February 17, 1937.

On February 15th, 1937, the following cult bills were introduced into the Legislature by Assemblyman Muir of Union County, who has introduced bills for these cults in previous legislatures:

A-233—To regulate practice of Naturopathy.

A-235—To regulate practice of Chiropracty.

A-236—To extend reciprocal provisions for practice of Osteopathy.

These bills are now being analyzed, and will be studied by our Legislative Committee who will report in detail on February 28th to the Welfare Committee.

These bills appear to be in line with previous attempts to remove the present restrictions on members of these cults who cannot qualify adequately as is required of Medical School graduates (M.D.s).

N. B. If we are to have changes in our present legislation to qualify as physicians and practice our own choice of the healing arts, the Uniform Medical Practice Act is available for this suggested change. Equal preparation and accomplishment for all is its goal and all who meet these uniform requirements may then practice whatever form of treatment their conscience and training dictate provided only that the patient and police will permit.

Other bills of interest to physicians will be listed on Bulletin No. 2 to be issued within a week.

B. S. Pollak, *Chairman.*

LEGISLATIVE BULLETIN NO. 2

Bulletin No. 2 was issued on February 23, and was as follows:

The following bills are of interest to physicians:

A-2—Muir, Jan. 18—Establishes New Jersey University as State University under management and control of State Board of Education. (Social Welfare Committee.)

A-34—Donohue, Jan. 25—Increases membership of State Board of Health from eleven to twelve and provides that one member shall be a practicing plumber. (Jan. 25, Public Health Committee; Feb. 8, reported by committee substitute; Feb. 8, read second time; Feb. 15, recommittted.)

A-94—Roye, Feb. 1—Imposes personal income tax at rates ranging from two to seven per cent of net incomes greater than $1,000. (Miscellaneous Business Committee.)

A-167—Muir, Feb. 8—Imposes personal income tax of 1.5 per cent of net income. (Miscellaneous Business Committee.)

A-233—Muir, Feb. 8—Creates State Board of five members to regulate practice of naturopathy; licenses naturopathic physicians; provides penalties for violations. (Miscellaneous Business Committee.)

A-235—Muir, Feb. 8—Creates State Board of Chiropractic Examiners, consisting of five members appointed by Governor, to regulate practice of chiropracty. (Miscellaneous Business Committee.)

A-236—Muir, Feb. 8—Extends reciprocity under osteopathic act until November 1, 1941. (Miscellaneous Business Committee.)

A-242—Roye, Feb. 8—Provides for custodial care and treatment by Health Department of deaf children under six. (Social Welfare Committee.)

A-244—Osmers, Feb. 8—Provides for annual eye and ear tests of pupils in public schools. (Education Committee.)

A-247—Stokes, Feb. 8—Provides for the sterilization of mental defectives. (Miscellaneous Business Committee.)

A-255—Taggart, Feb. 8—Amends Narcotic Drug Act to include marihuana or cannabis. (Public Health Committee.)

A-264—Brady, Feb. 8—Appropriates $30,000 annually to the Board of Beauty Culture for administration purposes. (Miscellaneous Business Committee.)

A-327—Freund, Feb. 8—Makes it mandatory for alleged drunken drivers of motor vehicles to submit to a physical examination to determine fitness to operate. (Miscellaneous Business Committee.)

S-6.—Bowers, Jan. 12—Requires registration of legislative agents and legislative counsel. (Revision of Laws Committee.)

S-54—Clee, Feb. 1—Enables Boards of Freeholders to purchase land and build cancer treatment hospitals. (Passed in Senate.)

S-90—Jamieson, Feb. 8—Amends Optometry Act relating to provisions and violations thereof. (Miscellaneous Business Committee.)

S-95—Burling, Feb. 8—Extends to children with chronic organic diseases, educational opportunities, provided for blind, deaf and crippled children. Education Committee.)

S-96—Burling, Feb. 8—Provides home educational facilities for physically handicapped children. (Education Committee.)

S-139—Clee, Feb. 15—Appropriates $2,500.00 to Department of Health for care and treatment of carriers of typhoid and other diseases. (Public Health Committee.)

S-140—Clee, Feb. 15—Permits State and local boards of health to proceed in Court of Chancery to enforce provisions of health laws. (Public Health Committee.)

The following bills relate to the Workmen's Compensation Act:

A-30—Ward, Jan. 25—Makes pneumoconiosis compensable as an occupational disease under Workmen's Compensation Law. (Miscellaneous Business Committee.)

A-73—Carlin, Feb. 1—Amends Workmen's Compensation Act by reducing burden of proof on injured employees seeking compensation for hernia. (Miscellaneous Business Committee.)

A-201—Szadkowski, Feb 8—Amends Workmen's Compensation Act by increasing penalties of employers failing to provide workmen's compensation protection. (Judiciary Committee.)

A-279—Kennedy, Feb. 8—Extends for one year act excluding releif workers from Workmen's Compensation Act. (Judiciary Committee.)

S-9—Bowers, Jan. 12—Excludes farm laborers from purview of Workmen's Compensation Act and Employers' Liability Act. (Judiciary Committee.)

S-81—Van Winkle, Feb. 8—Broadens protection to employees and their beneficiaries of insurance policies issued under Workmen's Compensation Act. (Banking and Insurance Committee.)

B. S. POLLAK, *Chairman.*

SPEAKERS' BUREAU

The following suggestions have been sent to the Chairman of the Public Relations Committee of each County Society:

Dear Doctor:

It is the aim of your State Committee to unify the aims and coördinate the activities of all County Speakers' Bureaus. This effort will achieve the greatest results. It is understood that you are now devoting your efforts to various meetings on *Venereal Diseases* as suggested in a previous communication. However, the following suggestions should not require much additional time:

To Parent-Teacher's Associations: It is urged that all addresses at Parent-Teachers Association meetings be on some phase of *Child Health,* at the preschool and school age level,—addresses to be on The Preschool Child, School Health, Whooping Cough, Measles, Diphtheria, Scarlet Fever, Smallpox, Infantile Paralysis, Eyes of the Children, Teeth, Tonsils, Colds, Tuberculosis, and Worms.

To Fraternal Organizations: It is urged that addresses to Service Clubs and Fraternal Organizations be on the problem of *health of adults,*—addresses to be on Health and Disease, Recreation and Exercise, Cancer, Diabetes, Pneumonia, Kidney Disease, Tuberculosis, Obesity, Mental Hygiene, Hay Fever, Vacations, Ventilation, Doctor Bills, and Health Examinations. In each address there should be a definite reference to the great progress made in treatment of each disease, and that this progress was due to efforts of organized medicine. Also, point out that the preservation of this unselfish philosophy of medicine is essential to further progress. Also be prepared to give talks on Medical Progress and Medical Economics if requested to do so.

To Women's Clubs: It is urged that all addresses to Women's Clubs be on *health problems peculiar to their sex;*—addresses to be on Tuberculosis, Cancer in Women, Constipation and Cathartics, Diets and Dietary Fads, The Family Medicine Chest, Gall-bladder, Goiter, Mental Hygiene, and Vacations.

It is suggested that your speakers be given an opportunity to choose their topic. Then request them to *prepare* their addresses. Information on all above topics can be secured from the Loan Collections of Hygeia Material on file in the Executive Offices, 137 East State Street, Trenton. *A complete list is enclosed.* If your speaker does not have sufficient time to prepare his address, we shall be glad to do so for him; but it is better for all concerned if each man will prepare his own presentation. To assure uniformity of advice and prevent conflicts in advice, it is recommended that all addresses be reviewed by a committee of your Speakers' Bureau.

The following Loan Collections of Hygeia Material is available from the Bureau of Health and Public Instruction, American Medical Association, 535 North Dearborn Street, Chicago, Illinois:

A star indicates that an outline on the subject is available.

Title	Number
Anesthesia	330.1
Anemia	92.1
Animal Experimentation	346.1
Athletics	318.1
Boys	124.3
Cancer	61.0
Cancer, Digestive Organs	51.1
Cancer in Women	54.1
*Child, Health of the School	401.1
Colds	151.4
Constipation and Cathartics	184.1
Communicable Diseases in the Home	47.1
Deafness	121.1
Delinquent Child	124.1
Diabetes	74.1
Diphtheria	10.1
Doctor	322.1
Doctor Bills	322.1
Doctor, Country	322.1
*Eyes, Adult's	120.1
*Eyes, Children's	120.1
Family Medicine Chest, The	327.1
First Aid	349.0
*Flies	331.1
Food Poisoning	302.7

Title	Number
Foods, Protection of	302.7
Gall-bladder	180.1
Goiter	81.1
Gonorrhoea	35.1
Hair	236.0
*Hay Fever	305.1
*Health Examinations	319.1
*Health Examination of Children	319.2
*Heart Disease	150.1
Hookworm	40.1
Industrial Health	348.1
Infantile Paralysis	16.0
*Insect Pests, Ridding the Household of	331.1
*Insects—Some Miscellaneous Diseases (Two outlines)	331.1
*Vacations	320.1
Ventilation	316.1
Vegetarianism	302.8
Vincent's Infections	21.1
Kidneys	194.1
Leprosy	33.1
Lighting	335.1
May Day	408.1
Medical Advances, Outstanding	338.1
Mental Hygiene, Child	124.2
Mental Hygiene, Adult	122.1
Milk	337.1
*Mosquito	38.1
Nails, Finger	238.2
Obesity	73.1
Old Age	261.1
Pets	20.1
Physical Education	318.1
Pioneers of Medicine	338.1
Play, Leisure and Recreation	320.1
Pneumonia	154.1
Posture	228.1
Preschool Child	257.0
Progress in Preventive Medicine	338.0
Radium	335.1
Rats	14.1
*Recreation and Exercise	318.1
Ringworm	233.1
Rheumatism	72.1
Scabios	238.9
Scarlet Fever	8.1
*School Health	401.1
Sex Education	422.0
Sunshine	315.1
Superstitions	333.1
Syphilis	34.1
Skin	238.0
Tapeworms	42.1
Training for Athletics and Health	318.2
Teeth	172.2
Tonsils and Adenoids	171.0
Tuberculosis	23.1
*Tuberculosis in Childhood	23.1
*Tuberculosis Physicians	23.1
Whooping Cough	9.1
Worms	42.1
X-rays	335.1

OFFICIAL CONNECTIONS OF PHYSICIANS

The Public Relations Committee of The Medical Society of New Jersey is collecting information regarding the connection of the members of the State Society with other organizations of a business, social, and fraternal nature. The object of the information is to secure a list of the members through whom the State Society may make contacts with other organizations whose activities may include the public relations of medicine. Through this list, the Public Relations Committees of the State and County Societies may arrange meetings on public health, and may make intimate contacts with the local organizations. Such information is necessary in order that the State Public Relations Committee may function efficiently and readily.

In order to secure this information, a questionnaire has been mailed to every member of the State Society asking for the following items of information:

Name and address of member organizations to which you belong.
Officer in what organizations?
Chairman of what committees?
Membership on the Boards of what State organizations? Also of National Boards?

This information, collated and filed in the office of the Public Relations Committee of The Medical Society of New Jersey, will enable the Society to make intimate contacts with all organizations whose activities include the field of medical relations. This list will include social and fraternal organizations through whom appointments for lectures may be made, and their support of medical projects secured.

JOSEPH H. KLER, M.D.,
Chairman, Public Relations Committee
of The Medical Society of New Jersey.
77 Livingston Avenue
New Brunswick, N. J.

PERIODIC LETTER TO MEMBERS—No. 3

Letter No. 1 was printed in The Journal of November, 1936, page 651; and No. 2 in January, 1937, page 43.

Dear Member:

1. *Legislation.—On* February 15th, 1937, Assemblyman Muir of Union County introduced bills to establish separate boards to license Naturopaths and Chiropractors in New Jersey, and to give them all the privileges of M.D.'s except prescribing inorganic drugs and doing major surgery. The Osteopathic amendment is contrary to the agreement under which we withdrew opposition to their bill in 1935.

These bills are A-233, A-235 and A-236. See your Legislator. *These bills should be defeated.*

Other legislative bills of interest to our profession will be listed in the March Journal. Each County Society Legislative Keyman now has a list of these bills to read at the next meeting of the County Medical Society.

2. *Organized Medical Service* to indigent and low-income groups—both for curative and preventive services, paid for in lowered fees through taxation or otherwise, necessitates *records* and the *prompt* completion of both the job itself and the essential facts required as a basis for payment and recording of the results obtained. Herein lies one of the most essential weaknesses in our coöperative plans to help the profession get more practice and more reward of negotiable value. One undoubted advantage of "State Medicine" is that complete records and prompt reports *can be had* upon demand. Each member should:

a. Keep *records* of essential data.

b. *Report* promptly upon required forms.

3. *Reports to County Medical Society*—At each County Medical Society meeting ample time should be allowed for the County Society representatives on State Society Committees to report back to the County Society concisely the essential facts regarding the subjects discussed, the decisions reached and the recommendations made at the State Society Committee meetings. This provision is essential to better understanding and coöperation. Full reports on State Society Committee meetings are printed in the Journal each month, but apparently few of the members read them. The Journal is a reporter of Society *activities* as well as a scientific Journal.

4. *New Jersey State Parents and Teachers* Association.—The "Summer Ronud-up" in New Jersey has been planned as a *coöperative* effort in which the Medical Society members will aid the P. T. A. in their attempt to get all preschool age children examined and records of their defects collected; and to have these corrected *before* the child enters school. The Medical Society's Preschool Age Record Card is to be used and every effort will be made by the Parent-Teachers Association to have children examined by their family physician. After a fair trial the refainder will be examined at a central place, and referred to the family physician for treatment. The indigent and low-wage will have to be included in this effort, or be cared for under a clinic arrangement. The Medical Society can win approval and support i fa proper *attitude* of helpfulness and interest is shown at this time.—Errors in procedure can be corrected as they are discovered in the course of the coöperative effort. A pleased parent will send more patients to a doctor than can be driven in by the various home visitors connected with official and non-official agencies.

5. *Social Security Coöperation.*—The Social Security Act is now *law.* The State Medical Society officers and Committee members are striving to see the provisions of the law are carried out through ways and means which are in accord with sound judgment and experience. Each member should keep informed on the Act itself, and on the recommendations of the Advisory Committees to the Welfare Committee. This is a big job—do *your* share to help in the work.

6. The advantage of an *Executive Committee* in each County Medical Society is definitely shown in the prompt response of County Medical Societies to suggestions and recommendations of the State Society Officers and Committee Chairmen. The State Medical Society wishes to thank the component County Societies for this coöperation; and urges each member to keep informed on the activities of his County Society and to feel an individual responsibility to carry out his assigned duties as a member of organized medicine. This is a vital part of the plans developed to protect the interests of the profession, and will result in a better distribution of medical services to all persons in need thereof, at a price which each can afford to pay.

7. *Annual Meeting.*—Progress reports on Scientific and Technical exhibits are very encouraging. The program will appear in the March Journal.

Plan now to be among those who will enjoy and benefit themselves throughout the meeting, April 27th, 28th and 29th.

DEBATE ON SOCIALIZED MEDICINE

The Plainfield newspapers carried a sensational account of a debate between Mr. James Rorty, Journalist, and Dr. J. B. Morrison, Secretary of The Medical Society of New Jersey, held in the Plainfield High School building, with Mayor Barlow presiding.

The debate itself seems to have been conducted with dignity and courtesy. The medical needs emphasized by Mr. Rorty were:

1. An educational program.
2. Group practice by physicians.
3. Greater efficiency.
4. A combination of health insurance, and an extension of public health services.

The implication of Mr. Rorty's address was that the medical profession of New Jersey was not promoting these four objectives. As a matter of fact, The Medical Society of New Jersey, which is "The Medical Profession", is putting forth every effort to promote all four of the objectives. It is entirely uncertain what was meant by "group practice". In some of the Western States where a plan called "group practice" is in force, it means a business partnership of specialists in several lines. In New Jersey the nearest approach to group practice is the service rendered by the largest and best equipped hospitals in which business relations are entirely subordinated to scientific diagnosis and relief to all patients regardless of their financial status.

Mr. Rorty was quoted as saying:

"Syphilis can be eradicated if just half the money spent by the Department of Agriculture to eliminate the cattle tick was provided for the medical purpose."

The implication, of course, was that syphilis can be eliminated by the forcible application of the compulsory methods of tick eradication, with the isolation of the affected persons, and the forcible application of treatment. If syphilis could be eradicated by one or two immersions of the patient in an antiseptic bath, it would be applied to human beings, just as procedures of a compulsory nature are applied to humans in such diseases as smallpox and yellow fever.

Arguments put forth by the proponents of State Medicine recall the monkey song in Kipling's Banderlog stories:

"Here we sit in a branchy row
Thinking of all the things we know,
Dreaming of all the things we do
All complete in a minute or two.
Something noble, and grand, and good
Done by merely thinking we would.
Now we're going to—never mind,
Brother, thy tail hangs down behind."

PARTICIPATION IN THE PUBLIC HEALTH PROGRAM

The following letter No. 2 has been sent to the Secretary of each County Society with the request that it be read at the next meeting of the County Society.

FROM THE PUBLIC HEALTH COMMITTEE

TO OUR FELLOW MEMBERS OF THE COUNTY MEDICAL SOCIETIES

A tremendous avalanche of new Public Health problems has been presented to The Medical Society of New Jersey in connection with the Social Security Act. These concern Maternal Health, Child Health, Crippled Children, Venereal Disease, Tuberculosis, the Blind, and Public Health Administration, and have perhaps left many of our members in confusion as to both the fundamental principles on which we are proceeding, and information regarding some of these fields.

We are, therefore, addressing this series of three letters to our fellow members, to be read by the Public Health Chairmen of the component County Societies. The policy by which we are attempting to work out our objectives was set up many years ago at the inception of this Public Health movement on the part of our State Society, namely—that the field of Preventive Medicine was rapidly slipping from the grasp of organized medicine; and unless strenuous efforts are made by our members to reassume responsibility for the preventive medical care of the community and county, the medical profession is in grave danger of losing its control of this most important service.

The fundamental principle on which The Medical Society of New Jersey is proceeding is that all people in New Jersey should be provided with *Better Medical Service.*

This must include:

a. Better curative medical care.

b. A complete health program guided by the family doctor, including the prevention of disease and the preservation of health from birth to the end of life.

Better curative medical service, and its economic phases is in the capable hands of Dr. Lewis and his Committee on Medical Practice, with its various sub-committees.

THE HANDBOOK OF PREVENTIVE PROCEDURES

The function of the *Handbook on Suggested Procedure in Preventive Medicine for the Family Doctors of New Jersey,* issued as a supplement to this issue of The Journal, is to assist each family doctor as a member of The Medical Society of New Jersey, in his individual task of serving as the *Family Health Adviser* who will guide the health program of each of his patients continually in the *prevention* of disease and the *preservation* of health.

The faithful service of over one hundred physician members of our Public Health Committee, with its seven Advisory Committees and twenty-one County Public Health Com-

mittees with their sub-committees, during the past six years has contributed steadily toward the realization of this objective, and all have had some part in the compilation of this Handbook.

All of us will feel well repaid if our labors aid our fellow physicians toward the preservation of private practice through improved practice of preventive medicine and health preservation for their patients. We are anxious that each member clearly understands that the better his practice of preventive medicine for his own patients becomes, the less will be the inevitable residue which his County Society must take care of in groups, and in conjunction with the health authorities of the communities. There is no question that the former is the best type of preventive medical care. The group method is an economical, but inferior method of preventive medical care. We, therefore, hope that each fellow member will begin by providing, and urging upon his patients, the preventive medical care outlined. The County Medical Societies have now assumed the responsibility of providing preventive medical care for all persons within their jurisdiction.

In each of the preventive medical fields The Medical Society of New Jersey, and the County Medical Societies, protect the interests of the member physicians, and maintain the ideals of preventive medical practice. This is accomplished by assuming full responsibility in each of these fields in coöperation with the official and non-official health agencies. In every case where this responsibility is not, or has not, been assumed by organized medicine, the official and non-official health agencies have assumed or will assume in the near future, this responsibility, to the detriment of the best medical service to the public. The past tendency, until very recently, of most of the official and non-official health agencies has been in the direction of the superficial type of medical service through employment of group methods of medical service. Only the physician himself, through his medical societies, can reorient this joint health effort gradually toward the better type of medical service,—the individual method,—by making his office a *Health Center for the Practice of Preventive Medicine.*

In this way, also, he can steadily diminish the number of persons given preventive medical service by group methods, by training himself in better preventive medical practices, and thus serving his own and other patients gradually attracted by the superior quality of his preventive medical practice.

While our physicians are conscientiously training themselves in these various fields of preventive medicine, with individual practice in mind, it may be necessary for our organized medical societies, jointly with the official and non-official health agencies, to carry on the bulk of preventive community medical service by group methods. These group methods will serve as *training courses* for our physician members. The public and private authorities and health agencies acquire confidence in organized medicine, and they will gradually accept the fact that to subsidize the preventive medical care of the low wage and indigent group in the individual doctor's own practice is the best form of preventive medical care. Thus the more quickly and efficiently the county societies take advantage of the remarkable opportunities now presented (post-graduate courses, handbook, and group method of training centers for physicians, etc.) to assist their member physicians in becoming more efficient in preventive medical practices and health supervision, the more real progress we will make toward undermining the threats of health insurance and state medicine. The wholehearted coöperation of each physician member in his County Medical Society, and his steady loyalty toward his County Society in its plans worked out for the solution of these problems adapted to each county's needs, and the individual physician member's determination that his personal practice of preventive medicine shall be of such a high quality as to not be even approached by any group inferior method of practice, will all result in the gradual shift, during the coming years, back from group methods to the individual, superior method of handling preventive medical needs through the actual accomplishment of making *"Every Physician's Office a Health Center".*

Stanley Nichols, M.D., *Chairman*
Public Health Committee of
The Medical Society of New Jersey

CARE OF CRIPPLED CHILDREN

March 3, 1937.

To the President of Each Component
County Medical Society:

Dear Doctor:

Commissioner Buch, of the Crippled Children's Commission of New Jersey, has just informed me that its field workers are beginning the periodic recheck of crippled children to see that these patients are continuing treatment until everything possible has been

done for them. It is the policy of the Crippled Children's Commission (and its workers are so informed) that, wherever possible, the crippled child be returned to his family physician, or to the specialist to whom he was referred by his family physician.

In indigent cases, the family physician consulted is urged to assist the Crippled Children's Commission visitor in finding a place where the indigent cripple can receive proper care.

This letter is to explain the aims of the Commission, and to urge that the members of The Medical Society of New Jersey assist, in every way, its worthy object.

LEROY A. WILKES, M.D.,
Executive Officer.

DINNER-MEETING OF N. J. CHAPTER, ASSOCIATION OF MILITARY SURGEONS

Forty-eight members of the Chapter assembled with their guests of honor at Essex House in Newark, on Monday evening, March 1st, to participate in the first of three Chapter meetings scheduled for the current season. Lt. Comm. D. B. Allman, M.C., U. S. N. R., the Chapter President, opened the meeting with formal toasts to the President of the United States, to the Navy and Army, and after greetings to the assembled company, turned the meeting over to Lt. Col. A. G. Hulett, Med. Res., U. S. A., the Chapter Secretary, who presided as toastmaster thereafter and appropriately introduced the guests of the evening, each of whom in turn addressed the assemblage.

The general theme of the evening was the urgent need for medical preparedness in these days, in view of the rearmament of the world powers, and after the catastrophic lessons gleaned from our unreadiness for adequate handling of the problems of 1917-19, and the new plans just announced for achieving efficiency in the various reserve Medical Departments of our defense forces,—peaceful purpose coupled with adequate readiness for defense being in all things a guarantee against foreign aggression.

Admiral Pryor, M.C., U. S. N., Retd.; Col. J. W. Grissinger, M.C., U. S. A.; Capt. William S. Bainbridge, M.C.-F., U. S. N. R.; Col. Sturgill, G.S.C., U. S. A.; Col D. A. Kraker, Med. Res., U. S. A., and Col. H. D. Corbusier, Med. Res., U. S. A., presented their views and admonitions based upon their individual experiences and assignments.

Captain Bainbridge, who is a Past President of the National Association, and Col. Corbusier, now Fourth Vice-President thereof, urged the members of the Chapter to plan not only to attend the next Chapter assemblage in Trenton (next month) but also the National Convention at Los Angeles in October, 1937.

The Chapter is growing steadily both in size and activity and promises to prove a forceful agent for promoting coöperative action by our medico-military officers of New Jersey.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS SINCE JULY 1, 1936

DIPHTHERIA TOXOID

County	To. Jan. 31	Month of Feb.	Total to Feb. 28	Average per Month
Atlantic	242	13	255	31.8
Bergen	987	80	1067	133.3
Burlington	189	30	219	27.3
Camden	462	2	464	58.
Cape May	50	2	52	6.5
Cumberland	240	2	242	30.2
Essex	8314	466	8780	1097.5
Gloucester	154	7	161	20.1
Hudson	114	6	120	15.
Hunterdon	23	83	106	13.2
Mercer	33	5	38	4.7
Middlesex	1006	1046	2052	256.5
Monmouth	570	6	576	72.
Morris	215	22	237	29.6
Ocean	178	55	233	29.1
Passaic	2683	223	2906	363.2
Salem	51	2	53	6.6
Somerset	1535	5	1540	192.5
Sussex	65	0	65	8.1
Union	800	41	841	105.1
Warren	353	5	358	44.7
Totals	18264	2102	20365	2545.6

SMALLPOX VACCINE

County	To. Jan. 31	Month of Feb.	Total to Feb. 28	Average per Month
Atlantic	424	8	432	54.
Bergen	903	10	913	114.1
Burlington	217	13	230	28.7
Camden	459	0	459	57.3
Cape May	57	0	57	7.1
Cumberland	321	15	336	42.
Essex	3517	259	3776	472.
Gloucester	307	4	311	38.8
Hudson	67	6	73	9.1
Hunterdon	21	0	21	2.6
Mercer	72	1	73	9.1
Middlesex	603	21	624	78.
Monmouth	1515	1	1516	189.5
Morris	757	42	799	99.8
Ocean	104	34	138	17.2
Passaic	1842	103	1945	243.1
Salem	32	1	33	4.1
Somerset	39	1	40	5.
Sussex	122	0	122	15.2
Union	979	50	1029	128.6
Warren	531	0	531	66.3
Totals	12889	569	13458	1682.2

BOOK REVIEWS

The American Medical Profession 1783 to 1850. Shafer, Henry Burnell. Columbia University Press, New York, 1936.

This volume is a study of those transition years from 1783 to 1850, the period in which medicine evolved from a colonial to a modern practice, a period which made possible the subsequent medical revolution. The author, always stressing the transition from old to new, discusses:

1. American Medicine at the Close of the Eighteenth Century.
2. Medical Education.
3. Medical Education, Studies and Problems.
4. The Practice of Psysick.
5. Medical Ethics and Fees.
6. Medical Literature.
7. Medical Regulations and Societies.

The author has consulted much primary source material of the period, such as medical magazines, college catalogues and fee tables, transactions of medical societies, and the accounts, day books, and diaries of practitioners. The result is an interesting and informative book that wll be enjoyed by the physician and the social historian.

Manfred Kraemer.

Passive Vascular Exercises and the Conservative Management of Obliterative Arterial Diseases of the Extremities. By Louis G. Herrmann, A.B., M.D., Assistant Professor of Surgery, College of Medicine of the University of Cincinnati and the Cincinnati General Hospital. With a foreword by Mont R. Reid, M.D. Cloth. Price $4. Pp. 288, with 84 illustrations. Philadelphia and London; J. B. Lippincott Company, 1936.

This monograph is concerned with the most recent development in the field of peripheral vascular disease, namely, treatment by rhythmic alternation of environmental air pressure. While it is written primarily for the guidance of those wishing to employ the alternating suction and pressure therapy, it actually covers the entire diagnosis and treatment of obliterative peripheral vascular disease.

The particular merit of the book is that it affords a wide knowledge concerning the peripheral circulatory disturbances representing the most recent advances in the treatment of a disease entity which had been previously recognized only in its terminal stages and treated by heroic and mutilating methods.

While a large part of the book is given over to the historical development of the use of suction to improve arterial circulation in the extremities, the chapter nevertheless represents a valuable contribution to the history of medicine.

The physiology of peripheral circulation and the psysiologic effects of changes in environmental pressure and temperature are fully discussed. The mechanism of collateral circulation and its spontaneous and therapeutic development are studied.

While the emphasis is laid on passive vascular exercise as a therapeutic measure, other therapeutic measures directed toward an adequate collateral arterial circulation are given their proper place. Of interest is the routine procedure used in the Peripheral Vascular Clinic of the University of Cincinnati.

This monograph is a distinct tribute to the painstaking work and the tireless energy of the Cincinnati group in the development of a rational procedure in the management of peripheral vascular disease.

Henry H. Kessler, M.D.

The Harvey Lectures 1934-1935. Williams and Wilkins, Baltimore, 1936.

As stated in its constitution, the object of the Harvey Society is to diffuse knowledge in selected chapters of the basic medical sciences, through the medium of public lectures by men who are workers in the subjects presented.

This collection of papers admirably serves that purpose. This volume can be unreservedly recommended to any physician who wishes to learn of what is going on in the basic sciences. The lectures are easily readable and well illustrated. The table of contents follows:

1. The Etiology of Pernicious and Related Macrocytic Anemias.
2. The Significance of Amino Acids in Nutrition.
3. The Distribution of Yellow Fever.
4. The Processes of Urine Formation.
5. The Specificity of Hormones.
6. Circulation in Muscle Activity.
7. Pneumothorax in Treatment of Pneumonia.
8. The Isolation and Properties of Crystalline Pepsin and Trypsin.

Manfred Kraemer.

DECEASED PHYSICIANS—NEW JERSEY

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Joseph Baldwin	27	Jan. 5, 1937	Plainfield	Woodbridge	Acute cardiac dilatation.
Frank C. Bunn	68	Jan. 9, 1937	Orange	Same	Coronary thrombosis.
George B. Emory	55	Jan. 14, 1937	Morristown	Same	Endocarditis, streptococcus viridans
Charles V. Niemeyer	48	Jan. 11, 1937	Union City	Same	Myocarditis.
Charles P. Opdyke	74	Jan. 21, 1937	Verona	Same	Cerebral thrombosis.
Philip Wolfman	51	Jan. 3, 1937	Perth Amboy	Perth Amboy	Cerebral thrombosis.

CONTACTS AND COMMENTS

Be sure to come to the Annual Meeting
And receive from your friends a hearty greeting;

And bring your wife so she may be
A part of your fraternity.

As in the lobby and grill you sit
And partake of their feast of wisdom and wit,

Display your stock of twice-told jokes,—
They will seem new to other folks;

As you tell of your problems and your joys.
Give ear to the tales of the other boys;

Make yourself one of the medical guild
And be with its brotherly spirit filled.

The program is made with *you* in view,
With enticing things to see and do:—

Timely topics tersely treated,—
Wise discussions brief and heated.

When everything is done and said,
A paper heard is worth three read.

Hear the officers give their annual reports
And the cynics reply with inspiring retorts;

Hear Haggard bring wisdom and wit from Yale,
And Heyd State Medicine impale.

Who from the paths of virtue stray,
May hear from Parran a healing way.

See the technical exhibits your office to furnish,
And the scientific your brain to burnish,

X-rays and models, and broken bones,
Pathology, cancer, and kidney stones.

The Woman's Auxiliary will show
Mementos of doctors of long ago;

The hobbies that keep the doctors young,
And Art from medical sources wrung.

Dress up and at the banquet sit,
With brevity reigning, the soul of wit;

Then with the lovely ladies dance
'Till the wee small hours, as in a trance.

And when at last the meeting is ended,
You will call it the best you have ever attended.

A folder on Haddon Hall with a notice from the Chairman of the Committee on Program and Arrangements is being mailed from the Executive Offices to every member of The Medical Society of New Jersey, and will carry an appeal for his attendance at the Annual Meeting to be held during the last week in April. Every member will be susceptible to the appeal, and will plan to attend the meeting if possible.

The Medical Society of New Jersey has received notice that it must vacate its present rooms at 137 East State Street, Trenton, N. J., by April first. A similar notice was served on all the other tenants because the owners of the building will convert it into a department store.

New rooms for the Executive and Editorial Offices have been secured in the adjoining building of the Broad Street Bank, at 143 East State Street. They will be partitioned to suit the needs of our Society to much better advantage than the present rooms.

The Executive Offices will be a large room suitable for committee meetings, with a smaller room for the Editorial Department, and additional rooms for the assistants and for filing. The new rooms will be occupied soon after the middle of March.

There is a multiplicity of important contacts of representatives of other organizations which go unrecorded because news items regarding them do not reach the Editorial Offices. This department of Contacts and Comments is designed as a record of the important contacts which the members are constantly making and with increasing frequency.

An example of the important contacts which a physician may make is contained in the following appeal from Dr. W. C. Woodward of the Bureau of Legal Medicine and Legislation of the American Medical Association:

Every osteopath in the United States will be authorized to treat injured and sick employees of the Federal Government throughout the United States, on a par with fully qualified physicians, if Congress enacts a bill, H. R.-4650, to amend the United States Employees' Compensation Act, introduced by Representative Drew, of Philadelphia, Pennsylvania, an osteopath. An identical bill, S.-1233, has been introduced in the Senate by Senator Burke of Nebraska.

In the House of Representatives, the bill is before the Committee on the Judiciary. Pressure is being brought, it is understood, for an early and favorable report. Representative Frank W. Towey, Jr., of your State is a member of that committee. Will you not send him immediately protests from your association by telegraph or air-mail special

delivery letter, and send me a copy of your protests?

A response to this request has been sent from the Executive Offices to Representative Towey, Jr.; and also an appeal to the key men of each county society to send his protest against the bills.

Pure Food and Drug legislation is prominently before Congress. The bills of Senator Copeland would make the prosecution of offenders discretionary with the Federal authorities. Senator Moore of New Jersey has introduced a substitute bill which The Medical Society of New Jersey is supporting. This bill would make prosecution mandatory, and the very fact of that a suit is started is a great deterrent of fraudulent practices in the manufacture and sale of foods.

Dr. Kler is developing a comprehensive plan of publicity in connection with the Speakers' Bureau and other features of the Committee on Public Relations. He has established cordial relations with Dr. Townsend, Chairman of the New York State Committee on Public Relations, and the two committees will be mutually helpful to each other in informing the people of the views of the doctors in regard to the practice of medicine.

The Judicial Council held a meeting in Newark on February 7, and discussed the dual field of its activity. As an organized body, the Council has the judicial duty of deciding questions of ethics.

As an individual, each councilor is expected to visit the county medical societies in his district and be the liaison officer between the State Society and the county society organization. It was decided that since the President's Cabinet had made official visits to every county society, often accompanied by the Councilors, there was no need that the Councilors make the usual visits in an official capacity.

The Committee on Nursing met in Newark on February 7, and discussed a number of important problems, particularly the curriculum of the training schools, and the need for trained and supervised nursing attendants to replace the untrained practical nurses.

The Passaic County Medical-Dental Service Bureau, which was authorized by vote of the County Society on November 14, 1935, has functioned with satisfaction for over a year. It has now admitted Bergen County into partnership with directors chosen from both counties. The two counties have a population of about 650,000, divided fairly equally between the two counties.

The organization meeting of the Directors was held on February 25, and the Bureau is now ready to function in both counties.

The Bulletin of the Bergen County Medical Society for March has the following clear directions how the doctor may use the Medical-Dental Bureau:

"Any patient unable to pay cash for services of any kind rendered by you may use the Bureau.

"Instruct the patient to fill out the credit application form and return it to you. Then *you* fill out the payment agreement, which can be made for any period of time you desire, from three to ten months, or longer in exceptional cases. The patient then signs the agreement and makes the down payment. You forward the credit application, the payment agreement, and the down payment to the Medical-Dental Service Bureau.

"The Bureau then investigates the credit statement, verifies the facts, and if satisfactory, forwards a copy of the agreement to you, a receipt to the patient for the down payment, and credits your account with the amount paid, less the ten per cent deduction. You receive your check on the tenth day of each month thereafter.

"If you do not wish to be bothered with any of these details, you may send the patient with your introduction card direct to the Bureau office, and they will arrange the entire transaction.

"Remember, you may use the Bureau for hospital cases, or for consultations with other physicians. In such a case, the entire amount for all services will be budgeted and a pro-rata amount will be credited to each party involved. For example:

"Mrs. X requires an appendectomy. She is unable to pay for all of it at once. You have her fill out the credit application (or send her husband to the Bureau office). The entire bill would then include hospital charges, assistant and anesthetist's fees, as well as your own fee. The Bureau takes care of all the details, and each month forwards a pro-rata amount to each of the parties involved."

The Bulletin also has the following note regarding prescription blanks:

"The Bergen County Pharmaceutical Association had passed a resolution at their last meeting to discontinue individual pharmacists making up prescription blanks with advertisements and extending an invitation to physicians who desired blanks to communicate with the County Association who would be pleased to make them up as a unit rather than an individual pharmacist. The Executive Committee expressed their appreciation of this thought and action."

The medical history of the several counties of New Jersey is of great interest and intrinsic importance, and its study comes in waves, stimulated by the publication of an article by a physician historian.

Bergen County is publishing its medical history in a series beginning with that of January, 1937. While the available data is meager, its publication will doubtless lead to further discoveries.

Local studies in medical history is well suited to the Woman's Auxiliaries.

Every county society needs an executive office and a telephone. Eleven societies publish monthly bulletins, but only two or three give the address and telephone number of the Secretary or other executive officer.

We suggest that every issue of every Bulletin carry the name of the Secretary, his address, and his telephone number, in a conspicuous place on its front page.

We also suggest that the Editors of County Bulletins get together and adopt a uniform size and shape for the publications.

The March Bulletin of the Essex County Medical Society contains the names of its officers and committeemen. These names fill six columns each with about sixty names. Allowing for duplications, Essex County has over 200 of its members serving the Society in some active capacity—evidence of a *Society at Work*.

Between five and ten per cent of the physicians of New Jersey change their addresses in the course of a year. Although every effort is made to keep the mailing list in the Executive Offices correct, many addresses remain wrong because no one informs the office of the change.

The names and addresses on the Official List of members are those which are sent by the Secretaries of County Societies.

When you change your address, be sure to inform the Secretary of your County Society.

The Board of Trustees met on Sunday, March 7, in the Executive Offices, and held a six-hour session which was replete with interest from start to finish. The Board is the coordinator of the entire system of organization of the State Society. Every officer and committee of the State Society is an entity in its own field, working on a budget that is assigned to it at the beginning of the year. In making a budget for the coming year, the Trustees judge of the results attained by each committee during the past year, and allocate the funds for the continuance of its work during the coming year. The wisdom of the Trustees in assigning a proper balance of activities to officers and committees has been the basis of the progress and efficiency which has been demonstrated by every branch of the organization of the State Society during the past year.

The weekly Bulletin section of The Journal of the American Medical Association is a great improvement over the former monthly Bulletin, for it now carries news items of practical interest.

The issue of March 6 contains a quotation from an editorial in the Vancouver Medical Association Bulletin of February, 1937, which describes some of the undesirable features of the proposed plan for health insurance. This plan has been modified from time to time in such a way as to place more and more restrictions on the doctors who enter into the scheme. The closing paragraph deals with consultants and specialists who may be called to difficult cases, and says:

> "As for the consultant and specialist—these are asked to send in bills according to the schedule of fees of the British Columbia Medical Association, but what share of these they receive will depend, not on this valuation, but upon the proportion that the total bears to the amount in the fixed pool, which cannot be exceeded. No business man would consider for one moment signing any contract on such terms; no member of the Commission would ever consent to work under such conditions as that his salary would depend, not on agreement beforehand, but on the amount of money available after all expenses had been met. Nor should we agree to work on any such conditions."

The Journal also quotes from the Westchester County (N. Y.) Medical Bulletin five planks regarding medical policy. The fourth plank deals with the central idea which had been adopted in the Handbook of Preventive Procedures of The Medical Society of New Jersey and reads as follows:

> Fourth, that every general practitioner should actively take on himself the moral responsibility for "selling" and rendering the whole armamentarium of preventive medicine to all his own patients, constituting himself a deputy health officer whose responsibility for the health of his own families he would not be willing to relinquish or delegate to the official health officers and the clinics.

The memorial notice on page 133 of the February Journal was on the passing of Dr. Eugene Way, and not Dr. Julius Way, as stated.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

MARCH

2	Camden
2	Hudson
9	Bergen
10	Mercer
10	Ocean
11	Burlington
11	Essex
11	Passaic
12	Atlantic
17	Middlesex
18	Gloucester
18	Morris
24	Monmouth
	Sussex (At call of President)

APRIL

6	Camden
6	Cape May
6	Hudson
8	Burlington
8	Essex
8	Passaic
8	Somerset
9	Atlantic
9	Salem
13	Bergen
13	Cumberland
14	Mercer
14	Ocean
14	Union
15	Gloucester
20	Warren
21	Middlesex
27	Hunterdon
28	Monmouth

ATLANTIC COUNTY

E. H. Nickman, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held February 12, 1937, at the Ambassador Hotel, the President, Dr. John S. Irvin, presiding.

NEW MEMBER

Dr. Charles Schwinn was unanimously elected to membership.

PUBLIC HEALTH COMMITTEE

Dr. V. E. Johnson, Chairman of the Public Health Committee, made a detailed report of its first meeting.

With regard to the appointments to the Baby Keep-Well Stations in Hammonton and Minotola, it was decided that the Public Health Committee should make its endorsements as it sees fit.

MEDICAL ECONOMICS

Dr. H. L. Harley, Chairman of the Medical Economics Committee, made a very complete and detailed report on the abuse of medical practice in Atlantic County.

After a great deal of discussion it was decided that the March meeting should be an open one to which every physician in Atlantic County should be invited to discuss this report and what steps should be taken to remedy or modify this condition throughout Atlantic County.

POST GRADUATE EDUCATION

Dr. Sloan Stewart, Chairman of the Post-Graduate Education Committee, reported that a course of six lectures,—four medical, and two pediatric,—would be held starting March 10th in the Gold Room at Chalfonte Hotel. The charge will be $8.00 per person, and Dr. Stewart urged the members to enroll and pay their fees as soon as possible. If there are sufficient surplus funds, the Internes of the Atlantic City Hospital will be returned their fee at the close of the lecture course.

Dr. J. C. Brown, Chairman of the Maternal Welfare Committee, reported that post-graduate work was available at the Margaret Hague Hospital in Jersey City to anyone recommended by their county society.

WOMAN'S AUXILIARY

Dr. W. A. Blampin, Chairman of the Auxiliary Committee, reported that the Auxiliary had contributed $25.00 to the Red Cross for flood relief.

RADIO BROADCASTING

Dr. M. B. Holoman, Chairman of the Broadcasting Committee, reported that the programs will begin the week of February 15th, and that they will also be published in the Monthly Bulletin.

GENERAL ITEMS

A letter of thanks was received from Mrs. E. H. Harvey for flowers sent to Dr. Harvey, who is ill in a Philadelphia Hospital.

A letter from the President of the New Jersey State Medical Society was read, in which it was requested that all physicians follow carefully the plans of the State and County Public Health Committees lest the work be taken over by the U. S. P. H. S.

Union County's Secretary requested our support of W. B. Morris, M.D., for Second Vice-President of the New Jersey State Medical Society.

An invitation was extended to all members to participate in the Art, Hobby, Medical History Exhibits at Haddon Hall during the Convention of the State Society. Mrs. I. R. Bier will gladly give any information desired.

In a letter from Dr. S. P. Nichols, a request was made for any information obtainable concerning a national health insurance program being promoted by a lay group in Washington.

Applications from Drs. Bossert, Henderson, Madden, Axilrod, and Reyner to the Venereal Disease Control Committee were referred to the Director of Public Health of the New Jersey State Society.

A notice was read announcing that the Camp transparent woman would be at the Franklin Institute in Philadelphia during February.

Dr. W. J. Carrington requested the President to appoint a committee to investigate the advisability of incorporating this Society.

A motion was passed that the President also appoint a membership drive committee, since one-third of the physicians practicing in Atlantic County are not members of the County Society.

SCIENTIFIC

The Scientific Program of the evening was presented by Dr. H. M. Eberhard, Professor and head of the Department of Gastro-Enterology at Hahneman Medical College and Hospital, whose paper was titled "Discussion of Some of the Great Advances in Gastro-Enterology". The paper was discussed by Drs. Read, Andrews, and Scanlon.

Dr. Hepburn, Assistant Professor of Chemistry at the Hahneman Medical College, discussed a thermocouple which is used for the determination of temperature within the gastro-intestinal tract.

BERGEN COUNTY

LeRoy W. Black, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held at the Holy Name Hospital on Tuesday, February 9th. The minutes of the January meeting were read and approved.

MEDICAL-DENTAL SERVICE BUREAU

Dr. Russell K. Tether stated that all the plans had been made to join the Medical-Dental Service Bureau of Passaic County at practically no cost to us. Motion was unanimously passed that the Bergen County Medical Society join with the Passaic County Medical Society and become an integral part of the Medical-Dental Service Bureau. (See page 213.)

NEW MEMBERS

The following were elected to membership:

From Junior to Regular—

Dr. Joseph B. Basralian, Hasbrouck Heights

Dr. Samuel Loman, Cresskill

To Junior—

Dr. R. M. Dahlquist, Hackensack

The following applications for membership were read:

From Junior to Regular—

Dr. Theodore R. Miller, Hackensack

To Junior—

Dr. Nelson C. Policastro, Hackensack

COMMUNICATIONS

1. A letter from Dr. L. Armstrong, Secretary of the Union County Medical Society, requesting our endorsement of Dr. Watson B. Morris for the office of Second Vice-President of The Medical Society of New Jersey.

2. A letter from Dr. C. C. De Biaso in regard to an optometrist who had been appointed as a first-aid instructor in Rutherford.

3. A letter from Mrs. Ily R. Beir, Chairman of the Art, Hobby and Medical History Committee, asking for the distribution of entry blanks to those who have interesting objects to exhibit.

4. A letter from Dr. LeRoy A. Wilkes asking us to let him know of any reports of activities in Bergen County of Senator Wagner agitating for the support of a bill for national health insurance.

5. A long communication from Dr. Stanley Nichols, Chairman of the Health Department, explaining the position of the physician in the Public Health phases of the Social Security Act.

PHARMACISTS' PRESCRIPTION BLANKS

Dr. Barnet S. Bookstaver discussed the resolution of the Bergen County Pharmaceutical Association in regard to prescription blanks for physicians. He felt that this was a matter entirely for the pharmacists to settle.

SCIENTIFIC

The speaker of the evening was Dr. Cary Eggleston, Assistant Professor, Clinical Medicine, Cornell University Medical College. Dr. Eggleston gave a very clear-cut description of true and false heart disease. He presented case histories to illustrate the difficulties that might arise in determining true or false heart disease when a patient presented any one of the following outstanding signs or symptoms:

1. Systolic murmur.
2. Palpitation and tachycardia.
3. Pain.
4. Collapse.

Drs. Burton Opitz, J. D. Dickson, Paul A. Kennedy, L. W. Black and S. B. Reich took part in the discussion.

BURLINGTON COUNTY

Parry M. Scott, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held on the evening of January 14 at the Moorestown Field Club. The attendance was large, and among the guests present were three delegates from Gloucester County, Dr. LeRoy A. Wilkes, Executive Officer of the State Society, and Dr. Frank Overton, Editor of the Journal. President Small called the meeting to order at 9:30 p. m.

SCIENTIFIC

Dr. Howard C. Curtis, Chairman of the Program Committee, introduced Dr. George P. Muller, Professor of Surgery at Jefferson Medical College, who gave a most excellent paper on "Chronic Appendicitis". Dr. Muller's paper was ably discussed by Dr. Hammell P. Shipps and Dr. Thomas P. Summey, and a short general discussion followed.

COMMUNICATIONS

The Secretary, in his report, read the following communications:

One from Dr. George T. Tracy expressing to his fellows in the society his appreciation for a "most beautiful testimonial, and a grand desk chair".

One from the Philadelphia County Medical Society—an invitation to our members to attend the Second Annual Session of the Post-Graduate Institute of the Philadelphia County Medical Society in Philadelphia April 12th to 16th, 1937.

One from Sydney L. Wright, Associate Director, Medical Section of the Franklin Institute in Philadelphia, inviting our members to be the guests of the Institute at the first showing of the Camp transparent woman on Tuesday, February 2nd, 1937.

PHYSICIANS' CREDIT BUREAU

Dr. Parry M. Scott, reporting for the committee investigating the establishment of a Physicians' Credit Bureau, introduced the following motion, which was duly seconded and carried.

Resolved:

1. That the Burlington County Medical Society sponsor the establishment of an organization called the "Physicians Credit Bureau of the Burlington County Medical Society". The President shall be empowered to appoint a committee of five members, called the Sub-committee on Credit, who shall control directly the affairs of this Bureau. This committee shall be empowered to select a layman capable of carrying on this work with his own selected help, this man to be bonded and to get the permission of the committee before any procedure is carried out.

2. That the function of this Credit Bureau shall be twofold: (a) The furnishing of a bad debtor list to all members of the society who wish this service, this list to be revised and kept up to date as often as practical; (b) the collection of overdue accounts in an ethical manner without resort to legal measures except on permission or request of the doctor furnishing the account.

3. That in return for the service rendered in furnishing the Bad Debtor List, without charge to the society, each member should feel a moral obligation to furnish this bureau with his collectable accounts whenever possible, and to coöperate in every way with the head of this bureau, who shall in a sense be a representative of the society.

The President then appointed the Sub-Committee on Credit:

Parry M. Scott, Chairman

J. Howard Hornberger	George T. Tracy
John S. Conroy	Harry L. Rogers

POST-GRADUATE PLANS

In the absence of Dr. Meyer, Dr. Howard C. Curtis reported for the Committee on Post-Graduate Education and asked the opinion of the society on which plan to follow this year. On motion duly seconded and carried, it was decided to join with other societies as in previous years.

NEW MEMBER

Dr. Albert Camaroti, of Burlington, was elected to membership.

ADVISORY TO VISITING NURSE SOCIETY

The Secretary read a communication from the Visiting Nurse Society of Riverton, Cinnaminson and Palmyra, N. J., asking for the appointment of physicians to act as an advisory committee to the society; and upon motion duly seconded and carried Drs. Harry L. Rogers, Harry Bauer, and Dean H. Le Favor were appointed.

MATERNITY HOMES

The society approved the renewal of the licenses of Mrs. Mary Robbins, 408½ Main Street, Riverton, and Mrs. Mary Stackhouse, 1317 South High Street, Burlington, to conduct maternity homes.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was held on February 2nd, 1937, at 9 p.m. in the Camden City Dispensary Building, with Dr. B. F. Buzby in the chair, and fifty-six members present.

The Building Committee reported progress in the plans for the alterations of the auditorium and buildings.

Dr. Sharp announced an open meeting of the Committee on Contract Practice to be held on February 9th, 1937. At this time members of the society were requested to discuss their problems and views of Contract and Compensation Practice.

A committee was appointed to study the Medical-Dental Bureau Plan as it functions in Essex County with the possibility of applying it in Camden County.

Dr. James N. Barroway, Camden, N. J., was unanimously elected to active membership.

The resignation of Dr. H. F. Westcott was read and accepted.

SCIENTIFIC

The Scientific Program was very interesting and entertaining. It consisted of the following case reports:

Dr. Hyman Goldstein presented a case of osteoporosis circumscripts. This case was discussed by Drs. Becker, Decker and Buzby.

Dr. Grant Favorite (by invitation) presented a case of polyeythemia vera. This was discussed by Dr. H. I. Goldstein.

Dr. Albert Shafer's subject was brain abscess in a sixteen-year-old boy. Case was discussed by Drs. Becker and Goldstein. Discussion was closed by Dr. Shafer.

Dr. Kennedy presented the fourth case: Misdirected forceps.

Dr. H. B. Mark (by invitation) gave an address on diabetes in sixteen months' old child. This case was discussed by Drs. Hummel and Myers.

Dr. Thomas McGlade gave uni-lobar bronchiectasis and discussed the treatment as given. This was discussed by Drs. Scruggs and Goldstein.

Final case was presented by Dr. R. Wright. The case subject was bilateral renal calculus in a ten-year-old child. This case was discussed by Drs. Goldstein, Decker and Buzby and Dr. Wright.

The regular meeting of the *Camden County Medical Society* on January 5th, 1937, was called to order at 9 p.m. by Dr. B. F. Buzby, President.

There were eighty-eight members present, including Drs. Sherman and Diverty, delegates from Gloucester County, and Dr. Shipps, delegate from Burlington County.

MEMORIALS

David F. Bentley, M.D., read a resolution commemorating the death of Dr. W. W. Kain. He was one of the oldest and most beloved members of the society and had served it in many capacities.

Dr. T. B. Lee presented a resolution on the recent death of Mr. A. E. Sparks. He was the pharmacist for the Camden City Medical Dispensary, which he served conscientiously and well.

NEW MEMBERS

The following were duly elected to membership:

K. L. Athey, M.D., Camden, N. J.

G. M. Adams, M.D., Gloucester, N. J.

Dr. Grafton E. Day was elected an Honorary Member.

The resignation of Joseph E. Nowery, Jr., M.D., a member for twelve years in the society, was accepted. He has been a member in good standing for twelve years. He is moving to Massachusetts.

SCIENTIFIC

The speaker of the evening was Leonard G. Rowntree, M.D., Director of the Philadelphia Institute of Medical Research. He gave a most interesting talk on his favorite subject, "Endocrinology from the Internist's Point of View". The paper was discussed by Drs. Lee, Lippincott, Goldstein, Glover, A. B. Davis, Shipman and Mengel.

Dr. William T. Read, Jr., Camden, has accepted a full-time position as Junior Pathologist with the Haskell Institute of Industrial Toxicology in Wilmington, Delaware. He assumes this position January 1st, 1937.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

The *Cumberland County Medical Society* held its regular bi-monthly meeting on the afternoon of February 9th, 1937, in the Garrison Training School at Vineland, with the President, Dr. H. B. Walker, of Vineland, presiding. The following representatives of the President's Cabinet of The Medical Society of New Jersey were present: Dr. S. T. Snedecor, President; Dr. W. J. Carrington, First Vice-President; Dr. E. J. Hawkes, Second Vice-President.

Drs. Snedecor and Hawkes addressed the society on the economic phases of medical service to the indigent.

DIPHTHERIA IMMUNIZATION

The immunization of children against diphtheria and smallpox was discussed by Dr. E. J. Thaltheimer, aud suitable certificate blanks were distributed among the doctors present, who are all anxious to surpass the record of last year and make this the banner county of the State in the number of children immunized.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held on Thursday evening, February 11th, 1937, at the Academy of Medicine, Newark, and was devoted to the subject of *cancer.* President Edgar A. Ill introduced the principal speaker of the evening, Dr. Bernard Pierre Widmann, Director of the Radiological Division, Philadelphia General Hospital, and Assistant Professor of Radiology, Graduate School of Medicine, University of Pennsylvania. He spoke on "The Management and Treatment of Malignant Disease and the Value of Tumor Clinics". Dr. Widmann presented in an interesting, engaging and enthusiastic manner, his experience with malignancy of various parts of the body, describing the efficacy of treatment in the different locations and the relative merits of surgery, x-ray and radium, alone or in combination. It was a fine survey by an authority on the treatment of cancer.

Dr. H. B. Orton, of Newark, showed lantern slides giving some interesting statistics about cancer in Essex County.

The Essex County Freeholders had been invited to attend. One of the freeholders commented on the cancer problem, and offered coöperation of the Board.

IRVINGTON PHYSICIANS' CLUB

The Irvington Physicians' Club at a recent meeting elected the following new officers:

Ernest W. Mierau, President
Louis Noll, Vice-President
E. B. Lafferty, Secretary
Leonard Tushnet, Treasurer

The following were elected members of the Board of Trustees:

Eugene P. Schaefer — Frank A. Bien
Robert Y. Hubbard — Harry Horn
Maclyn F. Baker

The club meets at No. 1011 Clinton Avenue, Irvington.

ESSEX COUNTY ANATOMICAL AND PATHOLOGICAL SOCIETY

The Essex County Anatomical and Pathological Society announces a meeting of exceptional interest at the Academy of Medicine of Northern New Jersey, 91 Lincoln Park, Newark, N. J., Thursday, March 25, 1937, at 8:45 p.m. The main subject of the evening will be an address by Dr. Frank W. Konzelmann, Professor of Clinical Pathology at Temple University Medical School, Philadelphia, on "The Clinical Pathology of Bright's Disease". This paper will be discussed by Dr. Arthur M. Fishberg, Attending Physician to the Mt. Sinai and Montefiore Hospitals, New York. All physicians are invited.

ASHER YAGUDA.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The *Gloucester County Medical Society* held its regular monthly meeting in the Georgian Room of the Homestead Coffee Shop.

NEW MEMBERS

New members elected were Dr. Harold H. Hunter, of Paulsboro, and Dr. Earl Stephen Hollinger, of Clayton.

SCIENTIFIC

Dr. John Eades, of Philadelphia, was the principal speaker at the meeting, discussing "The New Methods of Treatment of Peptic Ulcer", in an interesting and instructive address. The attendance was the largest for several months.

Reports were presented by Dr. I. W. Knight, Chairman of the Public Health Committee, and by delegates to county societies. Following the meeting the Ladies' Auxiliary joined the members at supper.

Members present were: Drs. C. I. Ulmer and T. M. Gairdner, Gibbstown; J. Harris Underwood, W. E. Crain, Paul Burkett, Fuller G. Sherman, Ralph D. Moore, William Brewer, Harry Nelson, J. F. Hughes, Dorothy Rogers, Paul M. Pegau, E. E. Downs and H. B. Diverty, Woodbury; Edward Ristine and R. K. Hollinshed, Westville; Henry L. Sinexon, C. C. Sheets, Anthony DiMarino, Oran A. Wood and H. H. Hunter, Paulsboro; B. A. Livengood, Swedesboro; Ralph Venturo and W. W. Pedrick, Glassboro; W. G. Harris, Mullica Hill; M. F. Lummis, I. W. Knight, H. W. Wright and W. J. Burkett, Pitman; Don Weems, Wenonah; Frederick G. Wandall, E. S. Hollinger and A. G. Gillis, Clayton.

HUDSON COUNTY

J. N. Connell, M.D., Reporter

The regular monthly meeting of the *Hudson County Medical Society* was held on Tuesday, February 2nd, 1937, at the Carteret Club, and was called to order by the President, Dr. J. Lawrence Evans at 9:35 p.m.

SCIENTIFIC

Dr. Evans introduced Fred H. Albee, M.D., B.A., D.Sc., LL.D., F.A.C.S., who spoke on the subject "Reconstruction Bone Surgery", which he illustrated with colored moving pictures.

Discussors: Drs. S. B. Sprague, W. G. Doran, J. M. Rector, J. F. Londrigan, N. M. Alter, L. W. Dodson.

Dr. Evans also introduced Dr. A. J. Casselman, A. A. Surgeon, U. S. P. H. S., Consultant in Charge, Bureau of Venereal Disease Control.

Subject: "Venereal Disease Control by the Physicians".

Discussors: Drs. T. McG. Brennock, V. P. Butler, E. K. Gutmann, E. Daly. Discussion closed by Dr. Casselman.

SECRETARY'S REPORT

The Secretary, Dr. T. McG. Brennock, announced that on February 24th at the Y. W. C. A. at 8:00 p.m. the Jersey City Health Department will sponsor its first public meeting for venereal disease control, and will show a picture entitled "For Our Sakes". All are invited.

NEW MEMBERS

The following new members were elected:

Dr. Michael W. Agolia, 1347 Boulevard, West New York; Dr. Louis A. Amdur, 834 West Side Avenue, Jersey City; Dr. Frank Roy Arndt, 217 29th Street, Woodcliff; Dr. Harry T. Aronowitz, 11 East 42nd Street, Bayonne; Dr. Frederick William Dershimer, 546 Bergen Avenue, Jersey City; Dr. Richard A. Cupaiuoli, 12 31st Street, North Bergen; Dr. Harry Feinberg, 73 West 32nd Street, Bayonne; Dr. Henry R. W. Finn, 84 Lembeck Avenue, Jersey City; Dr. Casimir F. Gadomski, Medical Center, Jersey City; Dr. Emil H. Crieco, 196 Broadway, Bayonne; Dr. John G. Imhoff, 55 Lincoln Street, Jersey City; Dr. Charles A. Landshof, 50 Glenwood Avenue, Jersey City; Dr. Peter Daniel Manno, 81 West 25th Street, Bayonne; Dr. Louis Meltzer, 32 West 33rd Street, Bayonne; Dr. Samuel J. Penchansky, 847 Avenue C, Bayonne; Dr. Eli Rubenstein, 79 West 32nd Street, Bayonne; Dr. Anthony J. Saladino, 427 15th Street, Union City; Dr. Edward F. Salmon, 74 Fairview Avenue, Jersey City; Dr. Arthur B. R. Smith, 65 Tonnele Avenue, Jersey City; Dr. William Jay Snyder, 74 Columbia Terrace, Weehawken; Dr. Harold Sussman, 326 24th Street, Union City; Dr. Juliana Swiney, 325 Avenue C, Bayonne; Dr. Edwin J. G. Valentine, 559 Summit Avenue, Jersey City; Dr. Eli A. Wallack, 333 Fairmount Avenue, Jersey City.

HUNTERDON COUNTY

A. Louis Gramsch, M.D., Reporter

The regular meeting of the *Hunterdon County Medical Society* was held on the morning of January 26th at the Flemington Court House, Flemington, N. J. Those present were Drs. Harner, Closson, Baker, Cartisser, Garfinkel, Fuhrmann, Hamilton, Boothby, Lane, and Gramsch.

AMENDING BY-LAWS

The following amendments to the By-Laws were adopted:

Chapter 3, Section 1, shall be amended to read as follows: The Executive Officers of this Society shall be President, President-Elect, Vice-President, Secretary and Treasurer. The appointive officers shall be Executive Officer, Reporter and three Censors. The President shall appoint these officers as soon as possible after each annual election. All officers shall hold office until successors shall have been elected and appointed.

Chapter 3, Section 4, shall be amended to read as follows: In the absence of the President, the same duties shall devolve on the President-Elect, and in his absence, upon the Vice-President, and both being absent, the Society shall elect a President pro tem.

In order to comply with the desires of the New Jersey State Medical Society, in addition to the foregoing, two additional sections to Chapter 3 are necessary and they are presented as amendments.

Chapter 3, Section 9.—There shall be appointed by the President three standing committees, viz.: Legislation, Public Health, and Medical Practice.

Chapter 3, Section 10.—The Executive Committee shall be composed of the following: The President, President-Elect, Vice-President, Secretary, Treasurer, Executive Officer and the Chairman of the three standing committees. Three members of the committee shall constitute a quorum.

MEETINGS—SCIENTIFIC AND BUSINESS

It was voted that special meetings be held for scientific programs, and that the regular quarterly meetings be devoted principally to business.

CO-OPERATION WITH WARREN COUNTY

It was voted to coöperated with Warren County in a post-graduate course in Child Welfare to start in April and be held at the New Jersey Sanatorium in Glen Gardner.

The meeting then adjourned at 12:30 p.m. and the society went to the Union Hotel for dinner.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The regular monthly meeting of the *Mercer County Medical Society* was held in the Trenton Country Club on the evening of February 10th, with President D'Arcy presiding.

SCIENTIFIC

Dr. Millan J. Raisbeck, of New York, Consultant in Cardiology, McKinley Hospital, Trenton, gave an address on "Prognosis in Heart Disease".

EXECUTIVE COMMITTEE

The Executive Committee report embodied recommendations emphasizing the necessity of following closely the suggestions recently enunciated by the several Chairmen of State Committees and of President Snedecor, with particular stress paid to the establishment of a Speakers' Bureau.

PUBLIC RELATIONS

Dr. Watts, Chairman of the Public Relations Committee, reported progress, and referred to the vast amount of work involved at the present time with the many subdivisions attending the educational program.

POST-GRADUATE

Dr. Purcell, Chairman of the Post-Graduate Course, reported the final determination of subjects with the speakers, there being two courses, "A" and "B", which were both detailed. Final action, following the discussion, resulted in the motion that the entire membership be circularized with respect to the registration for the courses.

NEW MEMBERS

Drs. Joseph K. Bayne, Frank P. Guidotti, Evelyn M. Haines, Samuel B. Lapin and Irvin Levy were elected to active membership in the society.

MIDDLESEX COUNTY

J. F. Sandella, M.D., Secretary

The regular meeting of the *Middlesex County Medical Society* was held at the Hotel Pines in Metuchen, N. J., on February 17th, 1937, at 9 p.m., with President John H. Rowland presiding.

PUBLIC RELATIONS

Dr. Sherman, Chairman of the Public Relations Committee, read Dr. Kler's article in the February issue of the State Journal, page 112, and said that this indicated the direction and aims for which his committee was working. He mentioned the following activities:

1. Twenty men have offered to serve as speakers before lay groups. He wants more of the doctors to coöperate, because all lay organizations in the county have been contacted and speakers and subjects offered. The subject matter for these talks is to be obtained from the State committee in order that no objectionable matters be presented.

2. A committee of prominent men was organized in New Brunswick for the observance of National Social Hygiene Day on February 26th, 1937.

3. The winning over of the Parent-Teacher Associations in regard to teaching sex matters in the schools.

4. Dr. Kohlmer delivered an address in New Brunswick on the subject "Vaccination Against Certain Communicable Diseases".

TUBERCULOSIS COMMITTEE

Dr. Silk, Chairman of the Tuberculosis Committee, reported that at a joint meeting between the Middlesex County Tuberculosis League, the Board of Freeholders, and the County Society's committee on December 2nd, 1936, it was decided to accept the Middlesex Plan with just a few minor changes. This is quite an important victory for our county society. The plan will apply to case finding in the high schools in the first and fourth year classes.

The pupils are divided into two main groups, and all work is done by the family physician in his office. Parents and pupils are informed of the plan. All pupils are to be tuberculin tested, and positives are to be x-rayed. The tuberculin is furnished by the county to physicians who wish to coöperate.

The fee schedule to be paid by patient is as follows: Family income of $3000, $2.00 for tuberculin test; $5.00 for x-ray. In lower income groups, if patient can't afford full fee, then it is reduced by one-half; or if no fee at all can be paid, then the Tuberculosis League will pay the doctor at the half-rate fee. The family physician is the judge of the patient's status.

A sub-committee was formed with Dr. Silk in charge of x-ray, Dr. White in charge of tuberculin testing, and Dr. Jacobson to handle publicity. This plan is already in operation in some communities, and the doctors are contacted by mail in order to get up approved physician lists for each school. It was urged by Dr. Silk that we all cooperate to make this study worth while. The report was accepted.

VENEREAL DISEASE CONTROL

Dr. McKiernan read the report of the Committee on Venereal Disease Control. It advocated four things:

1. All new health officers should be physicians with training in health work.

2. Observance of National Social Hygiene Day.

3. That additional key clinics be established in Perth Amboy and South River (there is a clinic in New Brunswick); and that each have a trained staff with one supervising head.

4. That newspaper publicity be used, and social diseases be discussed in the press in order to awaken public interest.

This report excited a lively discussion. Dr. Sherman did not favor newspaper publicity, and said that great caution and a planned campaign over a long period was advisable. He cited the A.M.A. condemnation of the unrestrained newspaper publicity.

Dr. Fithian remarked that the proposal was in direct opposition to the Middlesex Plan concerning clinics.

Dr. McKiernan suggested that the county should reconsider its stand, and that these clinics would be established anyway, over our protest; and that we should anticipate public opinion in this regard.

A motion was passed to reject the report as given; and that the report be referred back to the committee for reconsideration.

Dr. Cronk spoke about National Social Hygiene Day program for February 26th. A motion was passed giving the event the official sanction of the county society.

MISCELLANY

Dr. Kler made a motion, which was passed, to the effect that a new lantern slide machine be purchased.

Dr. Spritzer asked in a letter that he be allowed to retain his membership in our county instead of Sussex, for which he had requested a transfer at the last meeting.

A letter was read from the Hudson County Medical Society extending an invitation to attend its meeting on March 2nd. Dr. Charles Gordon Heyd, President of the A. M. A., will deliver an address on "Classification and Treatment of Goiter". The meeting will be held at the Carteret Club, Jersey City, at 9:15 p.m.

Letters from the State Public Relations Committee and Public Health Committee were read. No action was taken.

There was a letter from Union County Medical Society endorsing Dr. Watson B. Morris for the Second Vice-Presidency of the State Society.

SCIENTIFIC

The topic "Hematological Problems in the Practice of Medicine" was presented by the guest speaker, Dr. Paul Reznikoff, Assistant Professor of Medicine at Cornell University Medical College, Associate Attendant Physican, New York Hospital, and Associate Visiting Physician, Bellevue Hospital. Dr. Reznikoff discussed the classification of anemias, and went into great detail concerning iron therapy, and the value and significance of white and differential blood counts in diagnosis and prognosis. Lantern slides were used.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

Another event in the recreationally instructive program to stimulate interest and increased attendance of members was held by the *Morris County Medical Society* the evening of Thursday, February 18th, 1937, at Spring Brook Country Club, in Morristown.

President Sherman called the meeting to order with about 125 members and guests present,—the attendance fully justifying the plan of interspersing the classic medical meetings with non-medical meetings presenting popular topics.

Captain Randolph P. Williams, U. S. A., Meteorological Officer, alternate pilot and grounds officer of the World Record Altitude Flight of the "Explorer II" into the stratosphere, proved to be a very happy selection. His presentation was not only entertaining but instructive and highly scientific, with many atmospheric and other factors of peculiar interest to medical men. With the aid both of still and motion pictures, Captain Williams covered all the details of preparation, the difficulties encountered, the elaborate array of highly sensitive scientific equipment necessary for the preservation of life in the high altitude attained and to record and bring back records of observations of very great scientific importance, and depicting the success of the ascension and descension and the attainment of the scientific aims and purposes for which the history-making expedition was sponsored by the National Geographic Society, and the U. S. Army Air Corp.

Captain Williams received unreserved applause and every one felt that they enjoyed a rare privilege in being present.

President Sherman impressed upon the members the importance of planning to attend the Annual Meeting of the State Society at Atlantic City April 27-29, 1937.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held jointly with the *Passaic Practitioners Club*, at the Passaic City Club, Thursday, February 11th, 1937, at 9 p.m. The meeting was opened by Dr. Lipton, President of the Passaic Practitioners Club, who then turned the meeting over to Dr. Norman Dingman, President of the Passaic County Medical Society.

Dr. Dingman first read a letter from the State Program Committee calling attention to the splendid Annual Meeting to be held at Atlantic City April 27, 28, 29, and he urged that as many as possible go.

A letter was then read from the State Public Health Committee urging active participation in the many phases of this public health program.

CANCER CONTROL

A report was then read by Dr. L. Shapiro on the activities of the Passaic County Medical Society Committee on Cancer Control. The suggestion was made that the present committee be appointed for a period of three years, and that power be given the committee to appoint a larger committee-at-large which would include a number of laymen and other interested individuals. On the motion of Dr. Ryan, seconded by Dr. Willard, this suggesiton was embodied in a resolution and unanimously carried.

HEADQUARTERS OF SPEAKERS' BUREAU

A report was then read by Dr. F. Vosburgh, Chairman of the Committee on Public Relations and Speakers' Bureau. He stated that progress had been made in securing a number of physicians as speakers on various subjects. He also stated that there was a definite need for a permanent location for contact with lay organizations. He suggested that steps be taken to secure a permanent location for the office of the Passaic County Medical Society to be used for the Speakers' Bureau and other County Society activities.

Dr. Levy then made a motion, seconded by Dr. Shapiro, that the officers of the society be designated as a committee to study and present to the society a budget providing for space and necessary clerical help for a permanent office location for the society. This motion was unanimously carried.

MEDICAL-DENTAL SERVICE BUREAU

Dr. Johnsen then gave a report on the activities of the Medical-Dental Service Bureau as follows:

In accordance with the instructions of the Pas-

saic County Medical Society, and the Passaic County Dental Society, at the request of the Bergen County Medical and Dental Societies, legal measures have been taken to change the incorporation of *The Medical-Dental Service Bureau of Passaic County* to *The Medical-Dental Service Bureau of Passaic and Bergen Counties.* The Board of Directors now consists of nine trustees selected by the Passaic County Medical Society; six trustees selected by the Passaic County Dental Society; seven trustees selected by the Bergen County Medical Society, and three trustees selected by the Bergen County Dental Society. The officers of the Board are:

Sigurd W. Johnsen, M.D., President
John Verduin, D.D.S., First Vice-President
Wright MacMillan, M.D., Second Vice-President
Norman Dingman, M.D., Secretary and Treasurer

The Bureau membership now consists of over 900 physicians and dentists, and has the support of all nine hospitals in Passaic and Bergen Counties.

The beginning of the second year of operation of this corporation, which is controlled solely by the Medical and Dental Professions of Passaic and Bergen Counties, opens with greater promise than ever before. More doctors are using the Bureau, and many patients are calling the Bureau office regarding medical and dental services. These requests, in all cases, are referred back directly to the patient's own physician or dentist, and as a result, a few doctors have come into the Bureau by the patient's request. (See p. 207.)

DOCTORS' SIGNS AND SPECIALTIES

Dr. Coogan then brought up the question of what was being done by the county society in prosecuting those guilty of contract practice and other unethical practices. A lively discussion was opened by this statement, and a number participated in the discussion. One special grievance was the prevalence of signs and notices in the offices of many physicians calling attention to various specialties.

A motion was made by Dr. Shapiro, seconded by Dr. Lomauro, that the Welfare Committee investigate these abuses and report back to the society a plan of action to correct them. This was unanimously carried.

WELFARE BOARD

Dr. Wright MacMillan then gave a report of the activities of the Welfare Board. He stated that the practice of county institutions in abusing medical services had been censured by the Welfare Board. A lively discussion followed this statement, but no resolution was passed on the matter.

NEW MEMBERS

The following members having been favorably passed on by the Board of Censors were unanimously elected:

Dr. Max Magnes
Dr. Martin Nemirow
Dr. T. C. Sabarese
Dr. Harry Yolken
Dr. K. Haitinger, by transfer from Somerset County

For Junior Membership—

Dr. Paul E. Rauschenbach.

THE MEDICAL-DENTAL SERVICE BUREAU OF PASSAIC AND BERGEN COUNTIES

The regular meeting of the Board of Trustees of the Medical-Dental Service Bureau of Passaic and Bergen Counties, Inc., was held at the Swiss Chalet, Rochelle Park, N. J., Thursday evening, February 25th, 1937.

The directors from Passaic County were hosts at a welcoming dinner to the trustees from Bergen County who were to be elected to the Board of Directors.

At preceding regular meetings of the Passaic County Medical Society, the Passaic County Dental Society, the Bergen County Medical Society, and the Bergen County Dental Society, resolutions have been adopted to operate the Medical-Dental Service Bureau jointly. The articles of incorporation were therefore changed, and the organization now is The Medical-Dental Service Bureau of Passaic and Bergen Counties, Inc.

The following members of the Bergen County Medical Society, having been nominated to serve as directors of the Medical-Dental Service Bureau, were elected by the Board of Directors as trustees:

Dr. Spencer T. Snedecor — Dr. H. B. Wilson
Dr. J. H. Irwin — Dr. H. Rheinhold
Dr. Charles Littwin — Dr. R. Tether
Dr. F. G. Dilger

The following nominations submitted by the Bergen County Dental Society were also elected as trustees:

Dr. Gifford Ely — Dr. A. L. Spiegelglass
Dr. A. Zabriskie

SOMERSET COUNTY

Albert W. Pigott, M.D., Reporter

The last meeting of the *Somerset County Medical Society* for the year 1936 was held at the Nurses' Home of the Somerset Hospital on the evening of December 10th, with twenty members present. President W. B. Gray presided.

ACADEMY OF MEDICINE

The Secretary read a letter from the Academy of Medicine of Northern New Jersey, inviting our members to become members of that organization for discussion and enlightenment along medical lines.

MATERNAL AND CHILD WELFARE

Dr. Ely outlined the work being conducted by the State Maternal Welfare Committee under their program of the Social Security Act. The establishment and management of Baby Keep-Well Stations was discussed and at the request of the State Society two members were recommended for the Manville and Bound Brook Stations. Those chosen were Dr. Pogoloff for the Manville, and Dr. Edelberg for the Bound Brook Stations.

COMMITTEE APPOINTMENTS

It was recalled that at the October meeting a complete reorganization of the Society, so far as committee activities are concerned, was effected. At that time the President stated he would announce committee appointments at the next meeting. The following committee appointments have been made:

Welfare Committee

Dr. E. T. Flint, Chairman
Dr. Dan S. Renner — Dr. R. F. Hegeman
Dr. A. F. W. Sferra

Legislation

Dr. Dan S. Renner, Chairman
Dr. J. H. Cooper — Dr. F. L. Field
Dr. L. Ely

Public Health

Dr. E. T. Flint, Chairman
Dr. G. E. Barbour — Dr. J. L. Young
Dr. I. C. East — Dr. Maurice Borow
Dr. E. G. Brittain — Dr. A. A. Lawton

Tuberculosis

Dr. E. T. Flint, Chairman
Dr. B. Wallach — Dr. J. L. Young

Maternal Welfare

Dr. A. A. Lawton, Chairman
Dr. E. Hird — Dr. John Cook

Mental Hygiene

Dr. I. C. East, Chairman
Dr. R. K. Adams

Venereal Disease

Dr. J. L. Young, Chairman
Dr. S. H. Pogoloff — Dr. A. W. Pigott

Crippled Children

Dr. B. Borow, Chairman
Dr. J. W. Crawford — Dr. W. Lovejoy

Cancer Control

Dr. E. G. Brittain, Chairman
Dr. L. Ely

Child Health

Dr. G. E. Barbour, Chairman
Dr. H. F. Day — Dr. S. H. Pogoloff
Dr. R. L. Cooley — Dr. H. Borow
Dr. S. S. Edelberg

Medical Practice

Dr. G. A. Greenberg, Chairman
Dr. A. A. Lawton — Dr. E. G. Brittain
Dr. R. F. Hegeman — Dr. A. F. Mangelsdorff
Dr. W. H. Long

Indigents

Dr. R. F. Hegeman, Chairman
Dr. F. L. Field — Dr. N. A. Falcone
Dr. J. H. Crawford

Contract Practice

Dr. W. H. Long, Chairman
Dr. D. C. Hamblin — Dr. T. H. Flynn
Dr. F. A. Wild

Nurses

Dr. E. G. Brittain, Chairman
Dr. H. F. Day

Hospitals

Dr. A. A. Lawton, Chairman
Dr. A. H. Dundon — Dr. Dan S. Renner
Dr. G. M. Bendix

Workman's Compensation

Dr. A. F. Mangelsdorff, Chairman
Dr. E. Hird — Dr. J. W. Crawford
Dr. J. L. Young

Pharmacists

Dr. G. A. Greenberg, Chairman
Dr. F. McConaughy — Dr. B. Borow

Public Relations

Dr. A. F. W. Sferra, Chairman
Dr. G. E. Barbour — Dr. L. C. Fritts

Functions

Dr. G. E. Barbour, Chairman
Dr. Mary L. Thomas — Dr. N. A. Falcone
Dr. G. A. Greenberg

Speakers' Bureau

Dr. L. C. Fritts, Chairman
Dr. A. S. Knight — Dr. R. K. Adams
Dr. J. Meigh

Contacts and Coöperation

Dr. A. F. W. Sferra, Chairman
Dr. S. H. Pogoloff — Dr. C. R. Kay

Post-Graduate Education Committee

Dr. Dan S. Renner, Chairman
Dr. S. H. Husted — Dr. J. Lovejoy
Dr. D. C. Hamblin

It was noted that a number of the new committee members rarely attend meetings or take any active interest in society affairs. The President stated that he hoped to stimulate their interest by placing them on committees.

The Treasurer made his usual plea for early payment of dues.

It was decided to supply lien blanks to the members, and the Secretary was instructed to obtain a supply of these blanks.

MEDICAL-DENTAL BUREAU

Following the business meeting, Dr. Murphy, of Roselle Park, discussed the Washington Plan from the physician's viewpoint, and Mr. Park, managing director of the Essex County Medical Bureau, discussed operation of this Bureau in Essex County. These two talks stimulated considerable discussion by the members.

The regular bi-monthly meeting of the *Somerset County Medical Society* was held at the Nurses' Home of the Somerset Hospital on the evening of February 11th, with twenty-one members present, and President W. B. Gray presiding.

POST-GRADUATE COURSES

Dr. Dan S. Renner, Chairman of the Post-Graduate Committee, outlined the proposed course to be given in coöperation with the State Society and Rutgers University. It would present two lectures

on x-ray film interpretation, two on arthritis, and two on proctology. It has been planned to have two lectures on child health with the lecturers supplied by the State Committee in charge of the administration of the Social Security Program, but it was learned that the full set of five lectures would have to be held in order to procure lecturers from this source. It was agreed that if enough members desire these lectures, they would be given in addition to the regular post-graduate course.

Dr. Karl Kornblum, of the Department of Radiology of the Graduate Hospital of the University of Pennsylvania, will give the two lectures on x-ray interpretation. The other two lecturers will be announced at an early date.

COUNTY BULLETIN

The President discussed the publication of a bulletin by the society, calling attention to the fact that such a publication represented considerable effort on the part of the Secretary unless all members coöperate in furnishing material for inclusion in the bulletin. It was the consensus of the members present that such an organ is definitely worth while, and expressed a desire to continue its publication.

NEW MEMBER

Dr. G. E. Lowry, of Skillman, was elected to membership.

The Hudson County Medical Society invited our members to attend their next meeting on March 2nd, at which time Dr. Heyd, President of the American Medical Association, will be the speaker.

SCIENTIFIC

Dr. Joseph Kler, of New Brunswick, spoke briefly on "Cancer Control in New Jersey"; and Dr. William G. Herrman, President-Elect of the State Society, spoke on the "Problems Facing the Medical Profession and the Program of the State Society in Solving These Problems".

After adjournment, delicious refreshments were served by the nurses of the Somerset Hospital to the members and guests and the Ladies' Auxiliary.

UNION COUNTY

C. C. Carpenter, M.D., Reporter

A regular meeting of the *Union County Medical Society* was held at the Elizabeth General Hospital in Elizabeth on February 10th, 1937, with Dr. Elmer Peter Weigel, the President, in the chair.

MEDICAL-DENTAL BUREAU

During the major portion of the evening the present and future needs of our Medical-Dental Bureau were discussed. This subject was introduced when Dr. Tom Walsh, representing the committee that guides the affairs of this bureau, frankly put it up to the society as to whether it wished this bureau to continue its activities. Although the members have been pleaded with to make use of its facilities, only about a quarter of the county's membership have given any active support. This has left the bureau in the bad position of being an active and fast growing concern, but still without sufficient backlog of accounts to take care of the necessary minimal expenses of paying the monthly cost of its maintenance. This gap between income and overhead is becoming less each month, but nevertheless the reserve funds that had been set aside are becoming so depleted that some further adjustment is immediately imperative if our bureau is to continue in operation.

Many members, including Drs. Crans, Able, Tidaback and Murphy, then spoke of their personal satisfaction in the manner in which their affairs had been handled by the active staff of this organization, and strongly pleaded for its continuance. It was brought out by Dr. Lance that probably the distance from the central office in Elizabeth made its use difficult by members who lived in the adjacent towns; but this could be overcome by the doctor making his own arrangements with the patients, and then forwarding a witnessed copy to the central office. Dr. Lance had attempted to start a branch office in his local hospital, where the doctors could more easily refer their patients.

It was Dr. Schlichter's belief that if this society failed in its own attempt to handle the financial problems of their patients, it would be an invitation for other outside lay or state organizations to step in and show us how to do it. Our President, Dr. Weigel, then pointed out that the dentists in this county have done their part in supporting the bureau's work. As there had been no dissenting opinions heard, Dr. Feidler moved that each member be assessed $5.00 to keep the bureau active; and Dr. Lance asked that this activity be continued for another year. Both motions were unanimously adopted, and the Secretary was asked to notify all members of the coming assessment.

PUBLIC HEALTH COMMITTEE

Dr. Burritt then submitted the following report and resolution for the Public Health Committee:

"We don't want to request a special meeting of the society, but unless the work of the society which the Public Health Committee is attempting to carry on is entirely understood by the other members, we shall be put into the embarrassing position of having the lay organizations know more about what we should be doing than we know ourselves.

"First, there is the work of the *maternal welfare* section, in which Dr. Staunton Davis is representing us. Dr. Bingham is the Chairman of the State committee. The State committee and the State Social Security agents have projected the institution of two additional maternal welfare clinics in the county. There is some evidence to support the opinion that these claims would be superfluous. Then, too, these agents are trying to make it mandatory that all private maternal homes have a registered nurse in constant attendance. As most of them have only two or three beds, and have a physician responsible, this also seems an unnecessary hardship.

"We have also to report misunderstanding about the *baby keep-well stations*, in which work Dr. Fred Lathrop advises us. Dr. Levy has explained this to me at some length. Many of the local authorities maintain nurses who have been keeping these stations with, or without, the attendance of a physician. There is no means of control over these sta-

tions except through the local authorities, and no social security funds to pay for their services.

"We had understood that reference would be made to the local physicians before any new baby keep-well stations were opened. This was not according to Dr. Levy's policy. Wherever the State places a child hygiene nurse, there will be a baby keep-well station. If the local physicians come to participate in these stations and receive remuneration for their services, they may; but the station will be established with or without the collaboration of the local physicians.

"We understand that there are certain parts of the county where changes are taking place under political guidance to establish new means of control of public health measures. In at least one such community these affairs are going forward without regard to existing provisions for medical and nursing care, and against the advice of professional and some lay groups. Your committee believes this to be improper.

"Our venereal disease section is busy preparing proper suggestions. A rather lengthy report was printed in the bulletin.

"Now we would say a few cogent words about the society's program for tuberculosis detection in juveniles. You all know the set-up of the resolution to test all children in the ninth grade by the Widal, x-ray, and the tuberculin reactions. We hope that every interested member will sign the blank printed in the bulletin, and mail it to my office in Summit, expressing his willingness to do the Mantoux tests in his town.

"The committee recommends that this be kept on a high-quality plane; and so Dr. Runnels will arrange to supervise the interpretations either himself or some one on his staff. So we all have an opportunity to learn something about tuberculosis that many of us need to know. The most important phase of this work is the follow-up of the positive cases and family contacts by the family physician to whom the reports will be made. Dr. Runnels is more than willing to assist by clinical instructional courses in the giving of the tests and the interpretations. Then in order not to lead to contradictions and lack of authority in interpretation of the x-ray findings, the Public Health Committee recommend that this work be done only by those men who are members of the Roentgenological Society.

"We cannot hope to have the tests cover 100 per cent of the proper pupils in the first nor second year. There will be much objection to the work, both by lay groups and by cultist; but let us hope that any criticisms by physicians will be voiced only here on this floor. Already we have heard some comments by really intelligent persons that there is dissention among us. This criticism of each other to laymen has always been the worst drawback to our profession. We have an opportunity in this program to serve ourselves by increasing our practice to include the care of many active and contact patients, and to render a monumental service to our communities. It is to our profit, and let us hope it is to our credit, to do a cheerful job well."

To return to a theme in the early part of this report, the Public Health Committee offers the following resolution:

"Where public health measures are now being carried on by existing and established practices, no change be made that is inconsistent with the opinion of the local physicians."

At first there was some disagreement among the members concerning the possibilities of establishing clinics in communities where the local physicians did not wish them; but when it had been pointed out that this was not intended, the resolution was adopted as read.

BOARD OF CENSORS

The Board of Censors, represented by Dr. Schlichter, read a letter from the Bar Association, inviting a representation from our society to a conference, at which it was hoped there would be obtained better understanding between the doctors and lawyers in such matters as the manner of giving court testimony, and the establishment of proper fees. Dr. Schlichter then asked for complaints of any doctors against members of the Bar Association.

SPEAKERS' BUREAU

Dr. Morris asked for more names to add to the list of speakers who would be available to address lay gatherings in this county.

SCIENTIFIC

The remainder of the evening was devoted to a paper read by Dr. Casselli, the adviser on cancer control to our Public Health Committee. He brought out the necessity of establishing in this county at one or more of the hospitals a *biopsy station* where section of tumors may be studied and classified. The station would be manned by men particularly interested in this problem who could give proper advice to the doctors who brought their problems to them. At some future time this would expand into a tumor clinic, which should be properly equipped to handle all phases of diagnosis and treatment and be similar to such clinics that are already in operation in Paterson and New York City.

He also stressed the need for acquainting the general practitioner with all the early phases of cancer, so that neoplastic lesions would be recognized earlier.

THE WOMAN'S AUXILIARY

PROGRAM OF ANNUAL MEETING

Haddon Hall, Atlantic City, N. J., April 27, 28, and 29, 1937

Please make every effort to be present for the *three days* of the Annual Meeting of the Woman's Auxiliary, April 27th, 28th, and 29th. In this way, you will be able to enjoy all of the social functions, as well as contribute your part to the success of the Auxiliary business activities.

The following is the completed program for the convention:

Tuesday, April 27th, 1937:

11:00 a. m.-3:30 p. m.—Registration, Lounge floor.

2:30 p. m.-3:30 p. m.—Executive Board Meeting, Mandarin Room, 13th floor.

3:30 p. m.-4:30 p. m.—Rolling Chair Ride, Boardwalk entrance (no fee).

4:30 p. m.-5:30 p. m.—Tea, Stair Hall (no fee).

8:00 p. m.—General Public Health Session for doctors and their wives, Viking Room, 13th floor.

Wednesday, April 28th, 1937:

9:30 a. m.—General Meeting, Mandarin Room, 13th floor.

2:00 p. m.—Fashion Show, Viking Room, 13th floor (no fee).

4:00 p. m.—Arts, Hobbies, and Medical History: Lecture and Tea, Benjamin West Room, 13th floor (no fee).

6:30 p. m.—President's Reception, Stair Hall, Lounge floor.

7:00 p. m.—President's Banquet and Ball, Rutland Room, 1st floor (fee $2.50).

Thursday, April 29th, 1937:

9:30 a. m.-10:30 a. m.—A. M. A. Convention Committee Meeting, Mandarin Room, 13th floor.

10:30 a. m.-11:30 a. m.—New Executive Board Meeting, Mandarin Room, 13th floor.

1:00 p. m.—Auxiliary Luncheon, Rutland Room, 1st floor (fee $1.50).

2:30 p. m.—Card Party, Derbyshire Room, 1st floor (no fee).

HEADQUARTERS

Haddon Hall—North Carolina Avenue and Beach, Atlantic City, N. J.

REGISTRATION

April 27th, 1937, Tuesday—11 a. m.-3:30 p. m.—Foyer, Main floor.

April 28th, 1937, Wednesday—8:30 a. m.-9:30 a. m.—Garden Room, Lounge Floor.

INSTRUCTIONS

1. Immediately on arrival at Haddon Hall, please present your credential card and register. You will then receive your program, badge and full information as to meetings and entertainment.

2. Only *delegates* are entitled to *vote*. *Alternates* have a *voice* and are expected to attend all sessions.

In the absence of a delegate, her seat should be filled by her alternate who, at that time, assumes all duties and privileges of the delegate.

3. Changes in duly accredited alternates may be made only on written request, signed by the County Secretary and approved by the Chairman of Credentials and Registration.

4. No one whose dues are in arrears may represent her county in any capacity.

5. No one may vote until she has registered.

6. Resolutions to be offered must be in writing, properly signed ,and in the hands of the Resolutions Committee at least twenty-four hours before the session at which they are to be presented.

7. Procure tickets for all activities in advance at the Registration Desk.

8. Send these instructions to your alternate if your are unable to attend the convention.

9. *Please help, by coöperating, to make this convention a splendid success.*

Committee on Credentials and Registration
Mrs. A. E. Jaffin, *Chairman.*

It will be a great help if the County Presidents will send to me by April 23rd a tentative list of reservations for the various functions. This reservation list may be added to at the time of the convention. County Presidents are also urged to take tickets for the Banquet and the Luncheon from the Convention Chairman at the Executive Board Meeting at Newark, March 8th.

Please feel that the Annual Meeting in Atlantic City is your convention. Your interest and coöperation will make it a success.

Mrs. Carl A. Surran
5 North Brunswick Avenue
Margate City, N. J.

ART, HOBBY, AND HISTORICAL EXHIBIT

Mrs. Adele M. Beir is sending the following appeal to all prospective exhibitors at the Annual Meeting:

Your exhibits in the Art and Hobby Exhibit at the Annual Meeting of The Medical Society of New Jersey have been greatly admired and have contributed much to the success of the exhibit and to the meeting as a whole.

We trust we may again have the pleasure of your entry this year.

Should you also have any instruments, medical curiosities or antiques, photos, pamphlets, documents, books, records, biographies, etc., bearing on Medical History, especially that of New Jersey matters or men, we would greatly value your entry of these.

We are arranging for better lighting of paintings at this year's exhibit, and will have more available floor space.

Enclosed you will find entry blanks. As the meeting is in April this year, I will appreciate the return of your entry by April first, so we may make adequate arrangements for the best display of your exhibit.

Very sincerely yours,
Mrs. Ily R. Beir, *Chairman*
Art, Hobby, and Medical
History Committee

QUESTIONNAIRE TO MEMBERS

The Woman's Auxiliary to The Medical Society of New Jersey is listing the social and fraternal connections of its members, and is securing data from its members by means of the following questionnaire:

Name and address.
Organizations to which you belong.
Offices held in those organizations.
Committees of which you are chairman.
Membership on the board of any State organization?
Member of what national boards?

This information will be collected by each County Auxiliary and will be collated by the Public Relations Committee, of which Mrs. A. Haines Lippincott, 406 Cooper Street, Camden, is chairman.

This data will be of great value to the Auxiliaries, and also to the Public Relations Committees of the State and County Medical Societies.

A similar questionnaire for physicians is printed on page 197.

COUNTY AUXILIARIES

Atlantic County

Reported by Mrs. L. M. Walker

A meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held on Wednesday, January 24th, at the Traymore Hotel, to discuss various activities and entertainment for the benefit of the members of the Auxiliaries of The Medical Society of New Jersey which comes here on April 27, and the American Medical Association, which meets here on June 7.

STATE PROGRAM

Events for the State meeting are scheduled as follows:

June 27, Tuesday afternoon, at 2:30, Rolling Chair Ride; 4:30, Tea.
June 28, Wednesday afternoon, at 2:30, Fashion Show; 4:00, Arts & Hobby Exhibit and Tea.

There will be no charge for the above events.

June 28, Wednesday evening, at 7:00, President's Banquet and Ball.
June 29, Thursday afternoon, at 1:00, President's Luncheon.

All of these events will be held at Haddon Hall Hotel.

NATIONAL PROGRAM

Arrangements for entertainment at the National Meeting were discussed, and details will be given later. Those present were: Mrs. Fitzgerald, Milwaukee, Wis., National President; Mrs. Augustus Kech, Altoona, Pa., National President-Elect; Mrs. George Rogers, East Orange, N. J., State President; Mrs. David Thomas, Lock Haven, Pa., Pennsylvania State President; and county members, as follows: Mrs. Carl A. Surran, Mrs. Percy Clark Joy, Mrs. V. Earl Johnson, Mrs. Baxter Timberlake, Mrs. Louis Rosenberg, Mrs. Samuel Salasin, Mrs. E. Harrison Nickman, Mrs. Morton Major, Mrs. Louis Feinstein, Mrs. Allen Reick, Mrs. Peter Marvel, Mrs. Ily Bier, Mrs. David B. Allman, Mrs. Anthony Merendino, Mrs. Daniel Reyner, Mrs. G. Ruffin Stamps, Mrs. William Carrington, Mrs. L. M. Walker, Mrs. James H. Mason, 3rd.

Essex County

Mrs. Frank S. Forte

On Monday, January 25th, the *Woman's Auxiliary to the Essex County Medical Society* held a reciprocity meeting for which 1400 invitations had been sent out to members and various organizations.

A board meeting and luncheon preceded the meeting. It was voted to present the doctors with one hundred dollars to purchase new chairs for the board room.

At the regular meeting, Dr. Edgar Ill, President of the Essex County Medical Society, lectured on "Why Physicians Oppose Plans for Health Insurance".

Dr. Harrison S. Martland, Chief Medical Examiner for Essex County, spoke on "Medical Detection in Crime", and showed pictures of various cases that he had autopsied.

Gloucester County

Reported by Mrs. Fuller Sherman

The *Woman's Auxiliary to the Gloucester County Medical Society* held a Valentine covered dish luncheon at the home of Mrs. E. E. Downs, South Childs Street, Woodbury, February 12th, at one o'clock. The committee in charge included Mrs. E. E. Downs, Mrs. Chester I. Ulmer, Mrs. Katharine Brewer, Mrs. Ralph Moore, Mrs. Ralph C. Venturo and Mrs. Fuller Sherman.

The regular monthly meeting was held Thurs-

day evening, February 18th, 1937, at 9 p.m. at the Homestead Coffee Shop. A bridge party was held following the meeting. Mrs. Theodore Gardiner and Mrs. I. J. Stewart were in charge. Later the members joined the doctors for supper.

Hudson County

Reported by Mrs. Joseph Murray

A regular meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held at the Y. W. C. A., in Jersey City, on Monday, February 1st, Mrs. A. E. Jaffin presiding. There were thirty-eight members present, and fourteen guests.

SPEAKERS' BUREAU

Mrs. Benjamin Macchia, Chairman of Public Health, in her report of the five-minute health talks, named the ladies who, at their various lay organization meetings, had read the paper of the month on pneumonia. She also reported that in response to a letter from Dr. J. H. Kler, Chairman of the State's Committee on Public Relations, asking our coöperation in the State's Venereal Disease Campaign, four lay organizations had already been provided with speakers on the "Venereal Disease Problem and the Method of Its Solution". The Auxiliary members were urged to contact the organization they represented so that meetings and speakers might be arranged as soon as possible.

A. M. A. RADIO

Through the Chairman of Public Relations, Mrs. James Murphy, it was planned to coöperate with the A. M. A. in distributing among the members of the Auxiliary the Radio Announcement cards, to be posted prominently in public places.

NEW MEMBERS

Mrs. Miles T. Long, Chairman of Membership, introduced two members, Mrs. Sina Singer and Mrs. Samuel Sandler, both of Jersey City.

Mrs. William Friele reported that several new books had been added to the Auxiliary Library; another copy of *Gone with the Wind* has been received; as well as copies of *Drums Along the Mohawk* and *Yang and Yin.*

DOCTORS' HOME

It was suggested by Mrs. J. Ruvane that, inasmuch as the idea of a "Doctors' Home" seemed rather vague, the Auxiliary ought to consider applying our money to some other worthy project. It was deemed advisable to give the matter much serious consideration and postpone its discussion until the next meeting in March, at which time the Auxiliary would entertain suggestions from its members.

GIFT

A *Rummage Bag* for Crossnoor was reported filled and ready to be shipped to North Carolina.

NOMINATING COMMITTEE

A nominating committee of six members was appointed by the President to choose and present names at the May meeting for the office of a President-Elect, First Vice-President, Second Vice-President, and Recording Secretary.

Mrs. William C. Stuart, of Hoboken, was hostess for the day and presided at the tea-table with several assistants.

SCIENTIFIC

The speaker of the day was Dr. Charles C. Tillinghast, Principal of the Horace Mann School in New York Ctiy, and his topic was "Training the Parent". He stressed three essentials for the successful training of children:

First, thc emotional balance of the child;

Second, guarding against the parent's own emotions in thinking too much about the unbalance of the child; and

Third, understanding the child and keeping abreast of his vocabulary and development.

Dr. Tillinghast said that every home should be an intelligent one—the greatest difficulty was in dealing with the child's divided personality. The child should never be permitted to think his misdeeds were beyond his control. The hairbrush now and then was not to be despised.

"Beware of the psychiatric quack", said Dr. Tillinghast. "The medical quack is bad enough, the psychiatric quack much worse." He spoke of the Parent Training Classes, which were five times as popular as they were ten years ago. His talk was absorbingly interesting as well as amusing and entertaining.

Dr. Tillinghast remained after the meeting, and talked informally to the members.

Mercer County

Reported by Mrs. L. L. Friedman, Secretary

The all-day meeting of the *Woman's Auxiliary to the Mercer County Medical Society* was held on Monday, February 8th, at the Nurses' Home of Mercer Hospital. Surgical dressings for the hospital were made throughout the day.

The business session was conducted by our President, Mrs. C. Chester Chianese. Reports from the Treasurer disclosed a neat sum after all bills to date are paid. Twenty-five dollars has been contributed to our local Red Cross Chapter toward the Flood Relief fund.

Mrs. R. J. Cottone, Health Chairman, reports that a two years' subscription to Hygeia has been placed in the five leading hospitals for use in waiting rooms and for nurses. Radio health posters were distributed to members, also in libraries, schools, and all public buildings.

A recording delegate, three delegates and three alternates were appointed to attend the State convention in Atlantic City in April. Members were urged to attend Art and Hobby Exhibit, and to enter as many objects of art as possible. We expect a beautiful display this year.

Elaborate plans are under way in regards to our Public Relations Tea to be held on Thursday, March 11th, at the Contemporary Club House, Mrs. Alton S. Fell in charge. A letter from Governor Hoffman accepting our invitation to be present at this tea was read.

Our guest speaker, Dr. J. Bennett Morrison, Sec-

retary of the New Jersey Medical Society, gave an interesting address on "The Stand of the Medical Profession Regarding Socialized Medicine".

Forty members attended the luncheon, which was in charge of Mrs. Edmund W. Burroughs.

In the afternoon a delightful talk by a prominent authority on women's apparel was heard. Mr. Breslow's topic was based on Spring fashion.

With about fifty members present, the Auxiliary spent a truly happy day.

Ocean County

Reported by Mrs. Emanuel Sickel, Publicity Chairman

A meeting of the *Ocean County Medical Auxiliary* was held at the home of Mrs. Robert Buerman, Lakewood, on January 15th, 1937. Five members attended. Plans for the Auxiliary's program for the Spring were discussed. At this point, I should like to mention that I felt the need for a knowledge of the routine work of other Auxiliaries in the State in guiding our projects.

Two constructive pieces of work that were done by our Auxiliary were reported. They include a substantial contribution toward the refinishing of the Orthopaedic Department of the Paul McKinley Hospital in Lakewood, and a donation towards the purchase of eight stretchers for the same institution.

Passaic County

Mrs. G. L. McCarthy, Reporter

The meeting of the *Woman's Auxiliary to the Passaic County Medical Society* was held on Monday, January 18th, 1937, in the Y. W. C. A. in Passaic. Reports were heard from Mrs. J. E. Mott, Mrs. J. Delario, and Mrs. N. Schulzo, after which refreshments were served by Mrs. L. Coen. Three new members were welcomed.

Dr. Foster Kennedy, neurologist, will speak at an open meeting of the Woman's Auxiliary to the Passaic County Medical Society to be held at the Woman's Club Monday afternoon, March 15th, 1937, at 2:30 o'clock. No charge is to be made, and the public is invited to attend.

Somerset County

Reported by Mrs. Charles F. Halsted

The *Woman's Auxiliary to the Somerset County Medical Society* held its regular meeting Thursday evening, February 11th, at 8:30, in the Nurses' Home, Somerset Hospital.

The President, Mrs. William Gray, presided. Plans for a card party were discussed, and an effort will be made in the near future to supply the physicians of our county with some necessary equipment.

Mrs. Brittain was requested to write to Dr. Morrison, and obtain a copy of his letter on Social Security.

Delegates appointed to the Annual Convention at Atlantic City April 27-29 are:

Mrs. William Gray; alternate, Mrs. L. Ely.

Mrs. Charles F. Halsted; alternate, Mrs. D. S. Renner.

Those attending the meeting were: Mrs. William Gray, of Plainfield; Mrs. D. S. Renner and Mrs. R. K. Adams, of Skillman; Mrs. E. G. Brittain, of Bound Brook; and Mrs. Lancelot Ely, Mrs. A. L. Stillwell, Mrs. R. F. Hegeman, and Mrs. C. F. Halsted, of Somerville.

After the business meeting, Mrs. Hegeman entertained with a reading on "Early American Homes".

Union County

Reported by Mrs. Helen M. Murphy

The *Woman's Auxiliary to the Union County Medical Society* held a regular meeting Wednesday evening, February 10th, at the home of Dr. and Mrs. C. H. Schlichter, of Elizabeth.

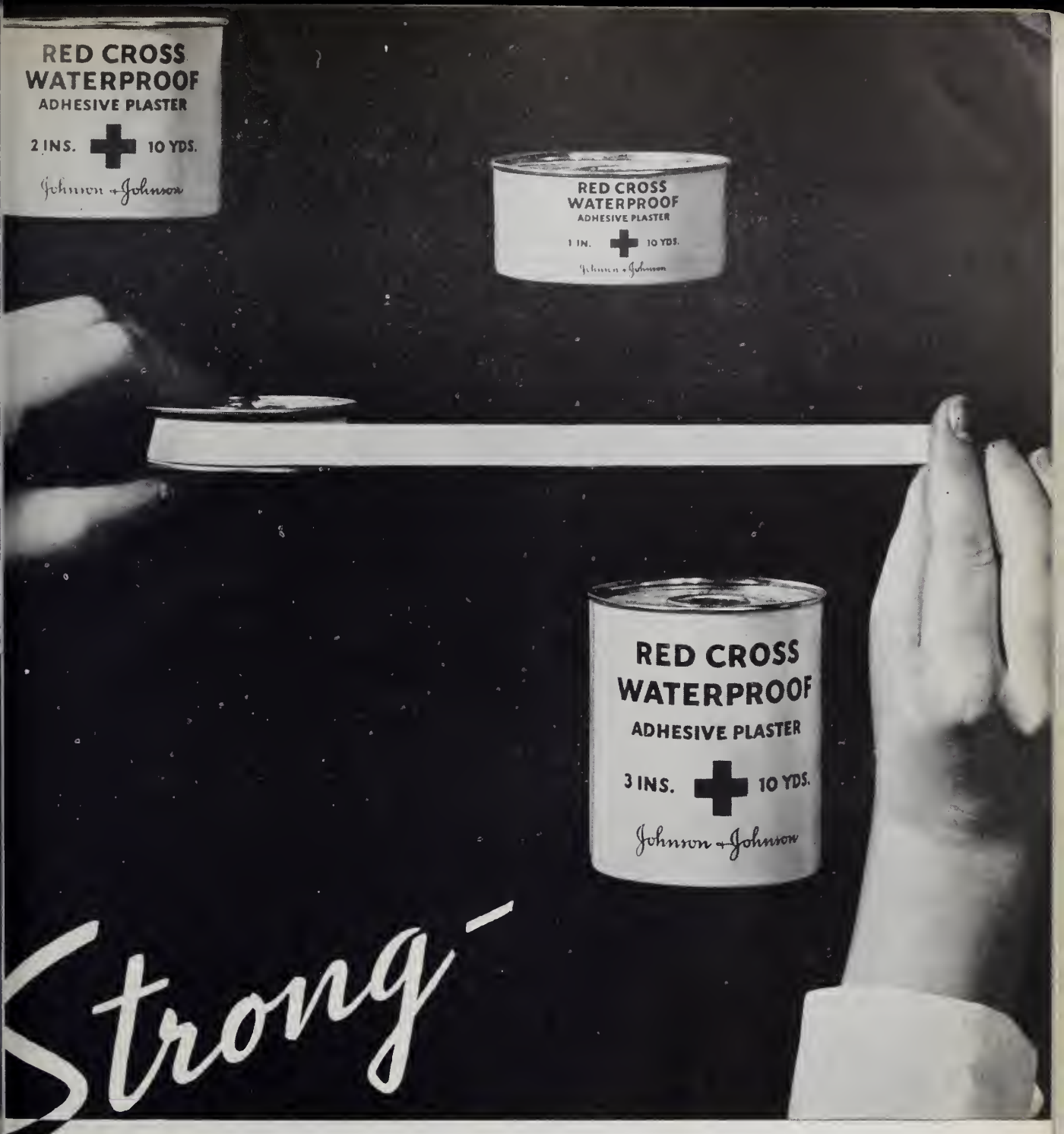
The slate of the Nominating Committee, headed by Mrs. H. V. Hubbard, of Plainfield, was presented. Director, Mrs. F. T. Hutton, Plainfield; President, Mrs. D. R. McElhinney, Elizabeth; First Vice-President, Mrs. H. S. Murphy, Roselle; Treasurer, Mrs. R. P. Blythe, Cranford.

The delegates and alternates for the State Medical Convention at Atlantic City, April 27, 28, 29, were appointed as follows: Delegates, Mrs. H. H. Bowles, Summit; Mrs. R. P. Blythe, Cranford; Mrs. C. H. Schlichter, Elizabeth; alternates, Mrs. L. H. Leggett, Westfield; Mrs. F. A. Williams, Elizabeth; Mrs. H. S. Murphy, Roselle.

Plans for a reciprocity tea to be given on March 23rd in Westfield were discussed.

Following the business, Dr. J. B. Morrison, Secretary of the Medical Society of New Jersey, spoke on Socialized Medicine as it affects the layman and the physician. "Only indigent cases should be cared for by the State; all others should pay their own bills," he stated. "Why single out medicine from other types of business to socialize?" he asked. The profession "would sink to the level of a trade" and the patients would suffer because the doctor would be forced to see so many patients daily that he would not have the time to devote to each one. It is up to each of us to see that these bills are defeated when they are presented in the State Legislatures and Congress.

At the close of Dr. Morrison's talk, refreshments were served by the hostess, who was assisted by Mrs. D. R. McElhinney, Mrs. G. A. Seymour, Elizabeth; Mrs. W. J. Hallock, Summit; Mrs. H. S. Murphy, Roselle.



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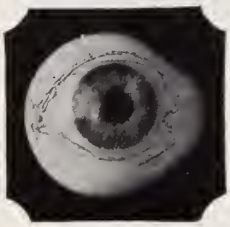
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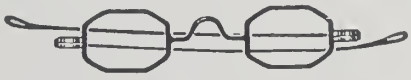
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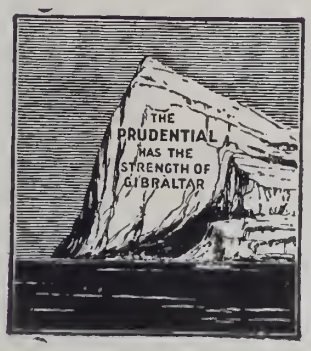
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VITAMIN REQUIREMENTS OF MAN

II. VITAMIN D

• The quantity of vitamin D required by an individual is influenced by such factors as environment, race, age, mineral content of the diet, and possibly by the source of the vitamin. Deficiency is manifest in children as rickets and decreased calcium retention, and in adults by the less well defined condition known as osteomalacia.

The minimum daily intake which will prevent rickets in infants is probably between 135 and 400 International units of vitamin D as supplied by cod liver oil (1). The optimum prophylactic dose is probably in the neighborhood of 1000 International units (2). It is also interesting to note that the League of Nations Technical Commission has recommended a daily intake of 340 International units of vitamin D for pregnant and lactating women (3).

Irradiated pasteurized milk containing 135 International units per quart and irradiated evaporated milk of the same potency have been found equally effective in preventing rickets in infants. The pediatrician will be interested in the following summary taken from a recent review:

> "Such evidence as is available may be interpreted to show that cod liver oil, cod liver oil concentrate milk, and irradiated milk are of equal potency for the human being, unit for unit." (1-b).

Other than the above recommendation for vitamin D intake during pregnancy and lactation (3), little definite information is available upon which to establish minimum vitamin D requirements of the human after infancy (1), yet while sunlight produces the anti-rachitic factor, most common foods are known to be deficient with respect to vitamin D (4). However, certain foods such as eggs, butter, liver and sea foods do supply this vitamin. The importance of sea foods, especially canned salmon, as carriers of vitamin D has been definitely established. A recent report on the vitamin D content of different varieties of canned salmon gave a value of 1.9 International units per gram for the least potent brand and 6 or more units per gram for several other brands (5).

From a consideration of the vitamin D values of salmon oil, the oil content of canned salmon and the quantity of canned salmon consumed annually in this country, it has been concluded that there is more vitamin D in the canned salmon sold in this country than in the cod liver oil used for both human and animal feeding (6).

Although neither the minimal nor optimal requirements of individuals of different ages are definitely known, the values of evaporated milk fortified with vitamin D and of canned sea foods as sources of this important vitamin, are well established.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) a. 1937. J. Am. Med. Assn. 108, 206
b. 1936. Ibid. 106, 2150
(2) 1936. J. Am. Diet. Assn. 11, 503
(3) 1936. League of Nations Report on Physiological Bases of Nutrition, League of Nations Publication Department, Geneva.
(4) 1935. J. Am. Diet. Assn. 11, 119
(5) 1935. J. Home Econ. 27, 658
(6) 1931. Ind. Eng. Chem. 23, 1066

This is the twenty-third in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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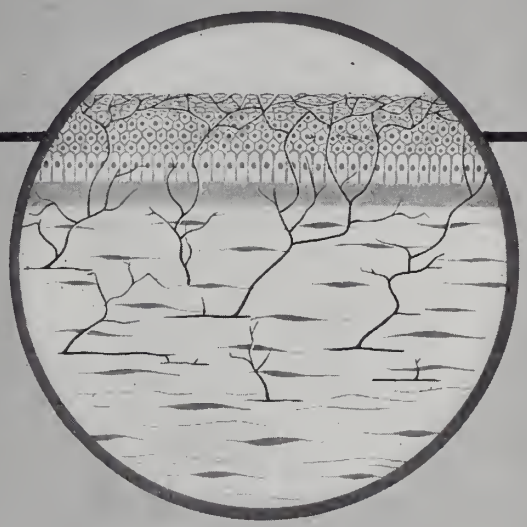
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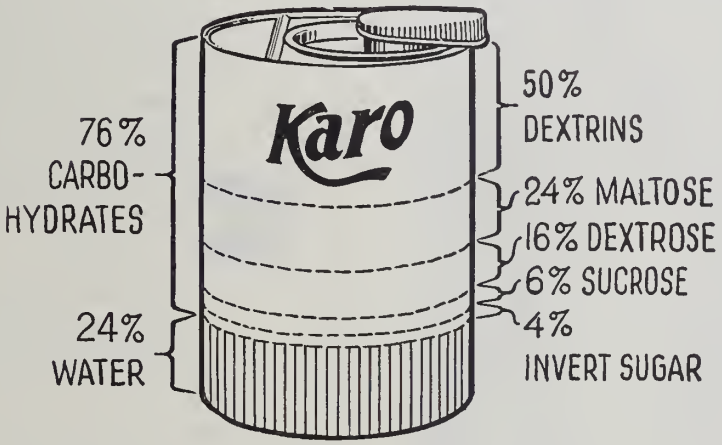
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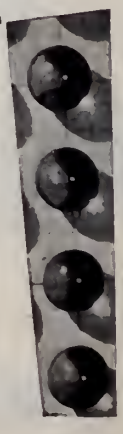


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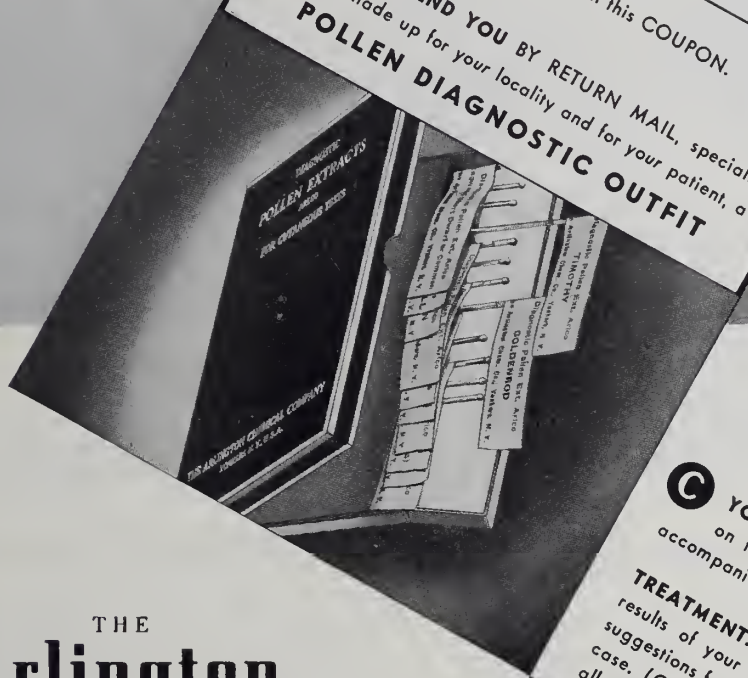
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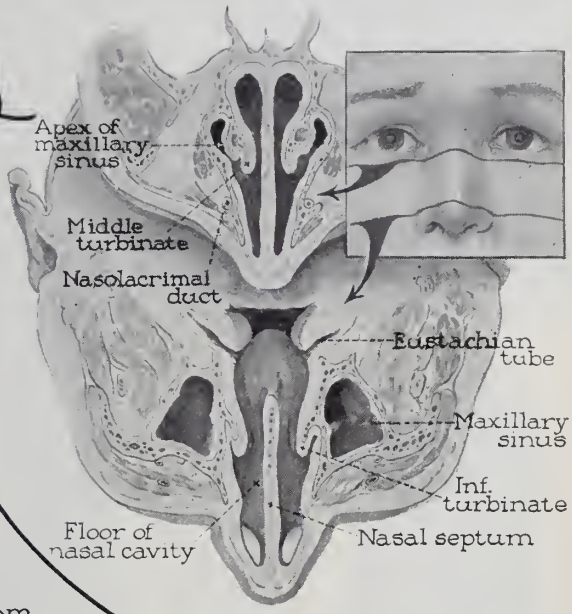
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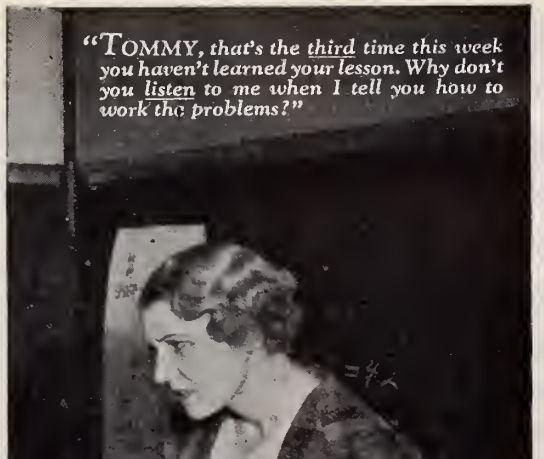
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Pablum offers a happy solution to the problem of the school-child's breakfast. Mothers who learn about Pablum from their physicians are delighted to serve it for it needs no cooking and can be prepared in a minute at the table—more quickly than many less nourishing foods. Pablum not only ends the bane of long cooking of cereals but in addition furnishes a variety of minerals (calcium, phosphorus, iron, and copper) and vitamins (B and G) not found so abundantly in any other cereal.

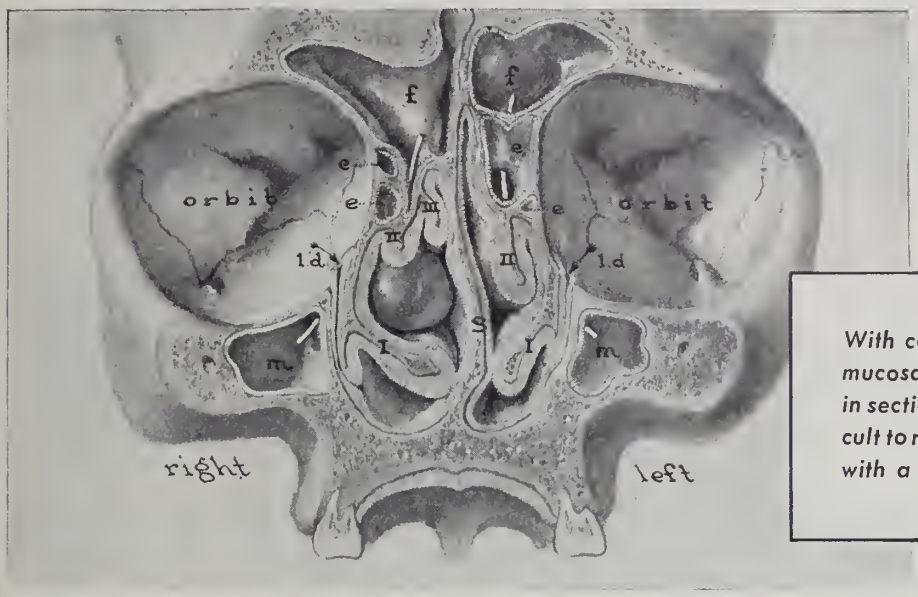


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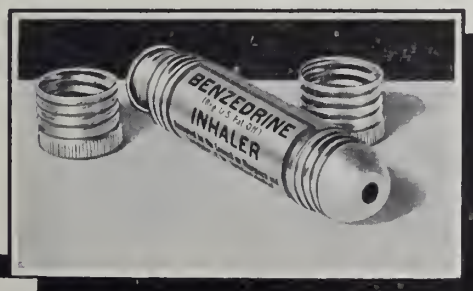


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'Benzedrine' is the trade mark for S. K. F.'s nasal inhaler and for their brand of the substance whose descriptive name is benzyl methyl carbinamine.

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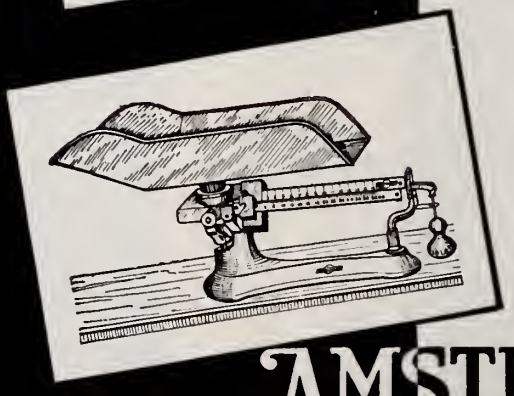
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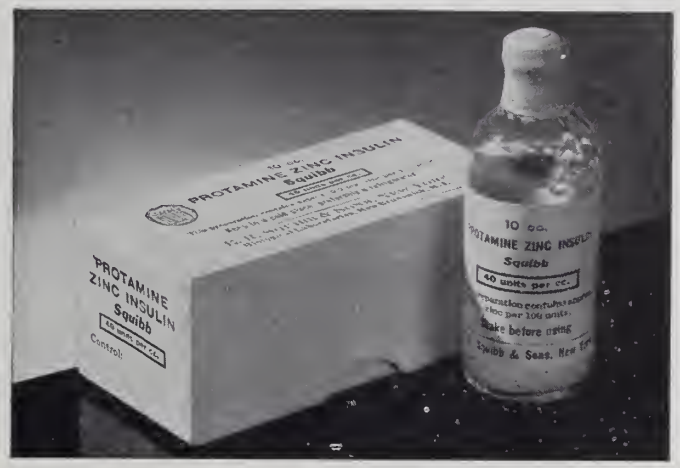
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1—The duration of action of a single dose is from about three to six times that of unmodified Insulin.

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5—Lessening of fluctuations in blood-sugar levels has a favorable effect upon patients' sense of well-being.

PROTAMINE ZINC INSULIN, *Squibb* complies with the rigid specifications of the Insulin Committee, University of Toronto, under whose control it is manufactured and supplied. It is available in 10-cc. vials. When this preparation is brought into uniform suspension, each cc. contains 40 units of Insulin together with protamine and approximately 0.08 mg. of zinc.

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Protamine, Zinc & Iletin (Insulin, Lilly) has been developed as a result of co-operation with Dr. H. C. Hagedorn and his associates of Copenhagen, Denmark, and the University of Toronto.

Eli Lilly and Company markets this product in packages containing one 10-cc. vial. After careful shaking, each cubic centimeter contains 40 units of Iletin (Insulin, Lilly) together with protamine and approximately 0.08 mg. of zinc.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly

Under the
Direction of the
Committee on Publication



Editor of
The Journal
Frank Overton, M.D., Dr. P.H.

Editorial and Executive Offices of the Society
143 East State Street, Trenton, N. J., Tel. 9330
Executive Officer—LeRoy A. Wilkes, M.D.
Each member of the State Society is entitled to receive a copy of The Journal every month.

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Single Copies, 30 Cents

EDITORIALS

The House of Delegates

The business, or "Economic", affairs of The Medical Society of New Jersey center in the House of Delegates, in which each county society is represented by elected members of its own selection, so that it is a thoroughly representative body. The actual meeting of the House of Delegates may be considered to have begun about the middle of March, when the officers and committees prepared their annual reports, which fill sixty pages of this April issue of The Journal. Since these reports consist of descriptions of progress that were authorized at the Annual Meeting of the House of Delegates in 1936, the coming meeting may be considered to be a continuation of that of last year.

Publishing all the annual reports a month in advance of the meeting was an innovation introduced by President Quigley in 1934, so that every member, whether he be a delegate or not, can read the reports at his leisure, and can come to the meeting prepared to discuss any phase of the work of the organization.

Furthermore, in order that every member may have an opportunity to express his views, the reports are referred to ten reference committees, each of which is assigned to a room where any member of the Society may express his views, and ask questions, and express his opinion freely and confidentially. In a very real sense then, the Annual Meeting begins when each member receives this issue of The Journal.

All matters relating to the actual practice of medicine have centered in the Welfare Committee throughout the year. Every problem has been first studied in detail by one of its fourteen advisory committees, each of which has held regular meetings, made surveys, and been in close touch with the county societies. Its conclusions and recommendations have then been considered by one of the four Sub-Committees of the Welfare Committee, and these again have been considered by the entire Welfare Committee, by whom the recommendations have been unified into a consistent series of reports. The system, far from being cumbersome, has worked as an inspiration to the advisory committees, to put forth their best efforts, as will be plainly evident to anyone who will read the annual reports with thoughtful consideration.

The Annual Meeting

The plans for the Annual Meeting of The Medical Society of New Jersey on April 27, 28, and 29, in Haddon Hall, Atlantic City, are more complete and comprehensive than ever before. The preparations center around three features:

1. Business
2. Scientific
3. Social

THE BUSINESS OF MEDICAL SERVICE

The production and distribution of medical services place the practice of medicine among the great public utilities of the country, ranking with manufacturing, transportation, churches, education, and law, as the fundamental basis of civilized life. In medicine alone among all the fundamental services are the participants voluntarily united in one great organization for the common purpose of giving the highest standard of service to every person in need.

On April 27th, the united medical profession of New Jersey will open its 171st Annual Meeting to discuss ways and means of distributing medical service throughout the State equably and efficiently, so that the pioneer in a thinly settled section may have access to medical service of the same standard as that which is available in the great centers of population. How to accomplish this purpose is essentially a problem in economics, in which every physician is vitally interested. In order to accomplish this objective, two great systems are proposed:

1. That of the Medical Profession by which the physicians themselves shall devise the ways and means of distributing their services, and the people themselves may choose their own medical advisers.

2. The socialized plan by which the government will attempt to distribute medical services according to the methods of "Great Business".

The officers and committees of The Medical Society of New Jersey discuss their plans and methods in the sixty pages of their annual reports which appear in this issue of The Journal, and which are available to every newspaper in the State. Every citizen can understand the high purposes of the medical profession if he will take the trouble to investigate them in the available records of the Society. Special provision will be made to publicize the information that will be made available at the Annual Meeting.

SCIENTIFIC

The Annual Meeting will also be a three-day school where physicians may learn the most advanced methods of producing medical services by means of lectures, demonstrations, and exhibits.

SOCIAL

Special effort will be made to develop that high degree of fraternity and mutual acquaintance among physicians which is essential for their efficiency in the practice of medicine.

The complete success of the Annual Meeting depends on the presence of yourself.

Relations of the Family Doctor and Voluntary Health Agencies

Voluntary health agencies are here to stay, for they can be of service to physicians who complain of the inability of a great number of their patients to apply the medical advice which is given to them by their family doctor. In every community there are voluntary health agencies,—Red Cross, Parent-Teacher Associations, Visiting Nurses' Associations,—whose services are available to the family doctor. These workers deliver social advice and economic services allied to those given by graduate nurses to bedside patients.

Physicians complain of the tendency of these workers to assume prerogatives which belong only to physicians. The class of patients to whom they are especially useful is composed

of those of low incomes who are chronically or frequently sick, because they lack the initiative to apply the doctor's advice. These patients constitute the majority of buyers of patent medicines and nostrums whose appeal is the alluring advertisements of sure cures. The money spent on these useless preparations is sufficient to purchase an abundance of medical service. A great field of the health workers employed by voluntary agencies is to give instruction to the patients on whom they call regarding the means of making use of the doctor's advice.

A physician can secure the helpful coöperation of the nurses and social workers by inviting them to give specified services to their patients, and to report on the progress which they are making. These workers can do much to counteract the appeal of patent medicines, and to hold the confidence of patients in their family doctors.

The Handbook of preventive procedures lists the accessory agencies on whom the family doctor may call for assistance, and is a major contribution of The Medical Society of New Jersey to the solution of the problem of maintaining the loyalty of the patients to their medical adviser.

The Pseudo Specialist

Most physicians in New Jersey are general practitioners,—meaning that they respond to calls to *persons* regardless of their sickness or infirmity.

The unit of the patronage of the general practitioner is the *family,* hence "Family Doctor" means the same as "General Practitioner", —and there is no confusion in the use of these two expressions.

A most common basis on which the Family Doctor chooses his patients, when he exercises his privilege of choice, is the social status of his patrons,—or in other words, their ability to pay him the standard fee for every call which he makes. He usually gets his start in his professional career in the tenement district, and "Enters the parlor through the kitchen", as the old saying goes. And it is to the credit of the successful Family Doctor that he usually "stands by" his early patients, although he may decline to take on new ones of those of low incomes.

In distinction from the Family Doctor, the "Specialist" chooses his patients on the basis of the *disease* which they have, or think they have. A favorite way by which a young doctor seeks to secure a profitable clientele is by posing as a specialist, especially in the nose and throat. Most persons have uncomfortable feelings in their noses and throats which are temporarily relieved by the sprays which the young specialist applies, for a fat fee;—and these patients return again and again, so long as their money lasts.

The real specialist attains his reputation from his brother practitioners rather than from the patients who come to him of their own accord. One way by which the Family Doctor may meet the competition of the pseudo-specialist is by equipping his office with the apparatus for giving all the simpler forms of treatment, and learning to use them conscientiously and efficiently.

The Medical-Dental Bureau

The physicians of New Jersey are slowly crystallizing their thoughts regarding the best method of delivering medical service to those who need it. The economic aspect of the problem has been the most difficult phase to solve; and the most promising solution seems to be that of the Medical-Dental Bureau.

A vital objection to compulsory health insurance is the certainty that the system will be abused to the personal advantage of those who will claim a serious disability, when only a minor one exists.

The advantage of the Medical-Dental Service Bureau is that it places the responsibility on three parties—where it belongs:

1. The physician, who supplies the services.

2. The patients, who are expected to do their part in carrying out the details of the doctor's advice, and paying him for his services.

3. Existing welfare agencies which will assist the bureau in investigating patients who are referred to the bureau.

The system is in one sense a development of so-called sickness, or health, insurance, but with these differences:

1. The Bureau functions only when sickness develops, and the patients who require medical services are in a mood to pay for them.

2. The payments which the patients make are for value already received.

3. The doctor is the party who assumes the risk, for he delivers his services without a deposit, and with no opportunity of taking back his goods on the patient's default of payment.

4. Welfare organizations make the arrangements for the price to be paid for the doctors' services, and for collecting it in monthly installments extending over a year only.

5. The system promotes harmony and mutual understanding between the medical profession and welfare organizations.

The system is making a slow but healthy growth. The latest extension in New Jersey is the acceptance of the physicians of Bergen County by those of Passaic County where the Bureau is already established.

Mental Therapeutics

It is a common expression among physicians that "You cannot do anything for that family", meaning that the head of the family lacks the initiative, the energy, and the persistence to carry out the necessary procedures which may be called "Personal" services. The Family Doctor is the principal source of inspiration to the patient, and of ambition and energy in the members of his family. It is his function to develop the body of his patient into a self-sustaining organism, working under its own power, and overcoming the obstacles of bodily helplessness, emotional weakness, and soul starvation. His field of service includes the mind and the soul, as well as the body of his patient; and extends to the other members of the family. In his work of rehabilitating the patient, the Family Doctor can utilize the services of visiting nurses and of representatives of welfare organizations and churches, provided he prescribes the general lines of service which they shall render.

The Annual Reports

The Department of Original Articles in this issue of the Journal is filled with the annual reports of the officers and committees to the House of Delegates. The change is more apparent than real, for the reports are much more than lists of items of work done; they constitute a vivid picture of Society activities, and contain discussions of the philosophy of the objectives that are sought.

The reports have been prepared with a greater amount of care and coördination than ever before. Those regarding the *internal* or business affairs have received the careful attention of the Trustees; while those relating to *external* contacts, or the practice of medicine, have been discussed in meetings of the Welfare Committee (p. 284) and received the approval of its fifty or more members.

The reports demonstrate the *need* for the activities of the medical society, and the *willingness* of a large group of members to volunteer for carrying them on. The next logical step will be to enroll every member as an active participant in the work of the Society.

THE MEDICAL SOCIETY OF NEW JERSEY ANNUAL REPORTS

of the

OFFICERS AND COMMITTEES TO THE HOUSE OF DELEGATES

April 27, 28, and 29, 1937

Index page 283

REPORT OF THE PRESIDENT

By Spencer T. Snedecor, M.D., Hackensack, N. J.

To the House of Delegates:

At the beginning of his term of office the President outlines his program for the year; and now when his year is over, he adds up the results in order to record the progress of the Society during his year of administration.

This Society of ours, the oldest in the nation, is active and growing, and in a healthy state. Not only have we attained our greatest membership during this year, but the individual members are making its welfare their personal concern, realizing the necessity of united action by the entire Medical Profession.

We shall make some personal observations on the welfare of the Society, but a careful analysis of the details of its activities and accomplishments is available at two sources:

1. The annual report of the officers and committees to the House of Delegates.
2. The current records of the committee meetings and conferences, which are published in The Journal.

In addition, there are two other valuable sources of information:

1. The unpublished records and summaries which are on file in the Executive Offices.
2. The source of material which is collected by the officers and committeemen, and which is invaluable in making further studies. Special effort should be made that this source of material be assembled and preserved in the Executive Offices.

EVIDENCES OF PROGRESS

A review of the annual reports of the last four years will be a liberal education for any person. Few physicians of New Jersey realize how far along the road of medical progress the Medical Profession of the State has gone in meeting modern demands and needs in the practice of medicine. Those needs crystallize themselves out of the experiences and discussions of your officers and committee members. Especially does their relative urgency receive attention in the Welfare Committee, where each of the component societies has a voice and a vote.

Your officers have persistently urged better organization and teamwork, and each year finds The Medical Society of New Jersey nearer this goal, with the gratifying result that each year more work is accomplished within a given time and with relatively greater economy. But the amount of work still to be done is great, and the potential dangers to organized medicine at this time are many, and require eternal vigilance and support of every member of the Society.

The alternative to immediate action is to await calmly the decision and action of our government, and accept its decision and dominance. A decision must be made now, and adequately supported by our State Society both in dues and in action.

ORGANIZATION AND TEAMWORK IN THE COUNTY MEDICAL SOCIETY

Organization and teamwork in the county societies are also advancing as fast as their officers can enlist the active interest and participation of the individual members in preserving private medical practice, and in helping to solve the many practical problems incident to Social Security legislation. Diagrams and charts showing the desirable relationships of The Medical Society of New Jersey to non-medical health organizations have been prepared and printed in The Journal, and in the Handbook of Preventive Procedures.

HANDBOOK OF PREVENTIVE PROCEDURES

An enlargement of the scope of the practice of preventive medicine by Family Doctors has been emphasized throughout the past year, stimulated by the operation of the Federal Social Security project. Eleven committees of the Welfare Committee were the central activating force in a comprehensive system of the practice of preventive medicine; and from it as a center there have radiated waves of influ-

ence which activated first the county societies and next their individual members by whom actual delivery of every form of preventive medicine is made. No form of preventive service is of value unless it is actually delivered to those who need it.

The number of preventive measures which are within the scope of the practice of a Family Doctor was found to be so great that it seemed wise to collect them in an available form, and in addition to list the organizations on whom the Family Doctor might call for assistance. The result of months of intensive planning was the *Handbook of Preventive Procedures* which was issued as a supplement to The Journal of March, 1937.

We regard this manual of preventive medical procedures as a major achievement of the year. It was conceived by Dr. Stanley Nichols, Chairman of the Public Health Committee; edited by Dr. Frank Overton, Editor of the Journal, and subscribed to by all the Committee Chairmen. We prophesy that this unique volume will be consulted far and wide as a model outline for the preventive medical practice of doctors at large. Of the seven active public health committees, those of Maternal Welfare, Child Health, Venereal Disease Control and Crippled Children have felt the strain of serious responsibility within the Social Security program and have performed their duties most creditably.

PUBLIC RELATIONS

We have witnessed the blossoming of a public relations plan which merits the wholehearted approval of the Society. It proposes to be the mouthpiece of organized medicine in the State to the people generally. By radio and press, and by association and contacts with influential groups, we shall spread our influence. In this day, the philosophy of the practice of medicine in the interest of our people requires interpretations to the public at large. Dr. Kler, Chairman of the Public Relations Committee, has conceived a broad program of extending medical information to all the social and health groups in the State through county and State committees.

THE INDIGENT

A definite approach has been made toward putting into effect our original plan of medical relief for the indigent. The State Financial Assistance Commission has approved the principles of medical care to be incorporated into its new manual on "Standards of Relief", which will be distributed to communities as a basis for allotments of relief money.

Our hospital relationships have improved apace. The sympathetic and appreciative officers of the State Hospital Association have sponsored jointly with us two meetings of hospital executives, trustees and doctors. We believe that these gatherings have been mutually valuable and profitable and we are certain that we are making headway toward the establishment of better hospital relationships and the control of medical practice in the hospitals. The reports of the survey of all the hospitals in the State contain many noteworthy conclusions which are to be found in Dr. Lewis' report. (P. 255.)

ANNUAL MEETING

We have stressed the importance and attractiveness of the Annual Meeting in order to make it of greater value to our membership. The several committees concerned with its promotion have each spent a great deal of time in making this coming session a success.

PRESIDENT'S CABINET

It has been our purpose to share the responsibility of our position with the other officers of the Society and to have them understand and act in accord with our work this year so that the program may continue without undue interruption in the succeeding administrations. This informal group we have called our "cabinet" and have often asked its members to represent us at county meetings which we could not attend.

Better organization in the State Society and in the county societies has been urged throughout the year. So many and so broad are the opportunities for medical group activity that our organization in the State Society has barely kept pace with the needs. We know that a number of the county societies have been almost overwhelmed with the diversity of activities but we do believe that every county society is becoming increasingly aware of its organization needs and is attempting to meet them as rapidly as possible.

RECOMMENDATIONS

As a result of my experience during the past year, I am submitting these specific recommendations to the House of Delegates for consideration:

1. That the tested reorganization and integration of the various committees under the Welfare Committee be approved.
2. That the Public Relations program as now getting under way, with plans for contacts and the spread of medical information, be endorsed.

3. That the general Public Health policies, as reported by the individual advisory committees, be supported and approved.

4. That the general policy of building up both the State and county society organizations, in order to more effectively preserve our practice and carry out our health responsibilities, be encouraged.

It is almost needless to add in conclusion that the President as one man can accomplish little. What has been performed during this past year has come through the untiring and understanding efforts of loyal officers and committees and of Executive Officer Wilkes. The willing response of every member on whom we have called to be our co-worker has been the inspiration of our year's work.

Respectfully submitted,
SPENCER T. SNEDECOR, M.D.,
President.

REPORT OF THE EXECUTIVE OFFICER

By LEROY A. WILKES, M.D., Trenton, N. J.

To the President:

Four years ago The Medical Society of New Jersey established central executive offices in which all its activities should center, with facilities for collecting and dispensing information regarding every phase of its work. The activities of the Executive Offices are allocated to two departments:

1. Administrative, under the Executive Officer, who, by assignment of the Trustees, is the full-time representative of the President.
2. Editorial, under the Journal Editor.

Miss Soden, secretary to Dr. Wilkes, also supervises the work of the clerical assistants, and also the details of filing, mimeographing, and keeping the business records. Miss Katz is the editorial assistant, and supervises the advertising pages. Two stenographer-clerks are also employed on full time. Every member of the office force is loyal and competent, and devoted to her assignment.

The coördination and coöperation of the two departments of the Executive Offices are a major factor in securing the efficiency for which The Medical Society of New Jersey is noted.

METHODS OF WORK

The work of the executive offices is carried on through:

1. Personal contacts, including visits, correspondence, telephone calls, and conferences.
2. Official records, both received and issued.

CONTACTS

The scope of the activities of the executive offices is indicated by the routine contacts which are maintained by the Executive Officer, and may be listed as follows:

1. The State Society, its officers and committees.
2. The component county societies, their officers and committees.
3. The individual members with their multiplicity of problems (limited).
4. Official Departments of Health, Welfare, and Education.
5. Voluntary health agencies.
6. Legislators, and other officials.
7. Hospitals and clinics.

The personal contacts maintained through the executive offices aid The Medical Society of New Jersey to assume its rightful place of leadership among the multitude of organizations engaged in health service throughout the State.

CONTACTS WITH COUNTY SOCIETIES

One of the most important contacts of the executive offices is that with the county societies. The means of making the contacts are most efficient with the larger societies, where office assistants are engaged. The occasions for calling the county societies by telephone are constantly increasing. Replies to inquiries by letter are often delayed because the local secretaries are not provided with stenographers. The extra charge for telephone calls made from the executive offices would go far toward the expense of an efficient office for each county society. Since the benefit to each county society is shared by all, it would seem that a large share of the cost should be borne by the State Society.

The minimum service that a county society requires is a central office, which would have the following functions:

1. Regular office hours, and a telephone service.
2. A clerk to receive mail, to communicate with the Secretary, President, or other officer, and to take dictation of letters and reports.

There is probably in every town a stenog-

rapher whose employment would permit her to spend some part of her time acting as clerk for the local county society, for a small additional compensation.

The Executive Officer suggests that the subject of a central office for each county society, with at least a part of the expense to be borne by the State Society, be referred to the Trustees for their consideration.

BULLETINS OF COUNTY SOCIETIES

The monthly bulletins which are issued by a little more than one-half of the county societies provide one excellent means of maintaining the contacts of the State Society and the local units with their members. These enlarged and informative bulletins are evidences of increasing interest and activity by the members; and they are constantly consulted by the members of the executive and editorial staffs of the executive offices in Trenton, where they are kept on file ready for use. If the improvement in the bulletins continues during the coming year at the rate of last year, each county society will soon develop a form of bulletin that is eminently well fitted for its own use.

RECORDS

Keeping records in available form is of equal importance with the coördinating work of making personal contacts. The executive offices maintain three classes of records:

1. The current reports of officers and committees of the State Society and its component county societies; and also of meetings held with allied organizations.

2. Summaries of the reports prepared for addresses and for publication in the current issues of The Journal, thereby making them available to every member and inquirer.

3. The source material on which the records and reports are based.

Every officer and committee accumulates records of all sorts, such as photographs, pamphlets, local reports, and newspaper clippings, which are usually discarded after the report has been compiled. It is quite the custom that the chairman of a committee shall destroy the material which he has summarized in his reports, rather than pass it along to his successor.

The Executive Officer suggests that, when a chairman retires from office, he shall send his source material to the Executive Offices where it will be preserved for future reference and study. It often happens that the source material is more clear and valuable than its interpretation contained in the formal report. (See President's report, p. 227.)

NEW EXECUTIVE OFFICES

The new Executive and Editorial Offices are now located in the Broad Street National Bank Building, 143 East State Street, Trenton, to which we moved on March 23rd, when the entire building in which our offices were located for the last four years was leased to a commercial organization for its exclusive use. We were fortunate in having free use of two extra rooms for nearly four years at our old location. Our new offices are admirably adapted to our needs and will permit of added activities as these may be found necessary.

FINANCIAL SAFEGUARDS

Total expenditures must necessarily increase with the enlarged scope of the Society's program and the wider participation in State and local affairs by our Society through its members; but the economical use of such funds is well guaranteed by your Finance Committee, your Treasurer, and your Executive Officer, all of whom are experienced in the use and accounting of funds entrusted to their care for legitimate use in carrying on the work of the Society, as approved by its duly chosen representatives.

OBJECTIVES

While the Executive Officer and the Editor have a place in practically every activity of The Medical Society of New Jersey, their relation to those activities may be compared with that of the Family Doctor to the expert consultant.

The officers and committees of the State Society are consultants and research workers, each in his own line of activity; and their reports, opinions, and suggestions compose the great bulk of the annual reports that are given to the House of Delegates. The peculiar place of the Executive Officer, and through him of the Editor, is similar to that of the Family Doctor who interprets the advice of the expert consultant to the patient and his family. In doing this, the Executive Officer and the Editor devote much thought and study to the conformity of new measures to standards and objectives which are held as fundamental by the Medical Profession of New Jersey in the following subjects:

1. Standards of medical service.
2. Hospital relationships.
3. Coöperation under the Social Security program.
4. Popular publicity regarding medical services.

1. ONE STANDARD OF MEDICAL SERVICE

Improved professional service to all in need thereof, at a price which they can pay, is a perennial objective of our profession everywhere, through research and post-graduate education. The Public Health Handbook is a pioneer effort to present to the general practitioner the special preventive and protective developments in medical practice which will more and more become his obligation and function, and will afford the public and the physician the best return for the time and effort spent. Preventive medicine is the field of practice not yet fully developed by the family doctor. Its development will bring to him increased opportunity, satisfaction, and dividends.

2. HOSPITAL RELATIONSHIPS

Improved hospital relationships, and better definition of, and agreement on, the proper scope of function of the Trustees, the Medical Staff, and the Administrative Superintendent, are urgent needs, and the time is ripe for organized efforts along these lines. The Hospital Survey is bringing us facts which will serve to indicate the reasons for many of our present difficulties; and on the basis of these facts our criticisms and suggestions can be clearly formulated and presented.

3. CO-OPERATION UNDER THE NATIONAL SOCIAL SECURITY PROGRAM

Widespread and active participation in approved medical services demanded under the National Social Security program. Much can be written on this subject, but committee reports will give the most helpful information to our individual members who should read each issue of The Journal from cover to cover in order to keep abreast of the increasing developments and the activities and plans of the Medical Society for widespread participation by our members.

This coöperation includes better integration of plans and activities of the various committees in connection with the Social Security projects, especially those included in the scope of responsibility allotted in our By-Laws to the Welfare Committee. It also includes provision of necessary funds and personnel to carry on the program and activities approved by the House of Delegates and Board of Trustees.

4. RELATIONS TO THE PUBLIC

Public Relations is a vital activity. Many people, especially social workers, nurses, and certain influential persons and groups, seem to feel that physicians are at times intolerant, dictatorial, and blinded by their own interests. This attitude is unfortunate toward the needs of the community and toward the plans and activities of other groups who feel themselves to be well established and necessary to the welfare of the public.

We need to know more of the work of these organized groups and the services which they offer; and they in turn need to know more of our aims and plans.

The Medical Society of New Jersey has made a noteworthy advance in improving our public relationships in both the State and the local communities; and the Public Relations Committee is just now becoming increasingly active under the able leadership of Dr. Kler, whose acquaintance among these groups is wide and influential. A friendly attitude coupled with interest and desire to know more about the work of other community groups and individuals begets a like interest in and a support of the medical profession and its plans and programs.

A CENTRAL AGENCY OF REFERENCE

In concluding this report, special attention is called to the function of the Executive Offices as a center where any member or organization may obtain information and advice in any branch of medical service.

Respectfully submitted,

LeRoy A. Wilkes,
Executive Officer.

REPORT OF THE TREASURER

By E. J. Marsh, M.D., Paterson, N. J.

To the House of Delegates:

Inasmuch as the fiscal year does not close until May thirty-first, no report of the Treasurer can be made until that time.

Respectfully submitted,

E. J. Marsh, *Treasurer.*

FINANCE AND BUDGET COMMITTEE

By Harry R. North, M.D., Trenton, N. J.

The Finance and Budget Committee will present its annual report directly to the House of Delegates in the form of a supplementary report.

Respectfully submitted,

Harry R. North, *Chairman.*

REPORT OF THE BOARD OF TRUSTEES

By Frederic J. Quigley, M.D., Union City, N. J.

To the House of Delegates:

The constitutional responsibility of the Board of Trustees to exercise general supervision over the affairs and activities of the Society—activities which are rapidly expanding—caused the agendas of every meeting of the Board to be unusually heavy; so much so that next year it will probably be necessary to hold meetings bimonthly instead of quarterly, as is the present practice.

The Board of Trustees has considered and disposed of all matters referred to it by the House of Delegates.

JUDICIAL DISTRICTS

The recommendation of the Councilors to increase the number of Judicial Districts to seven was adopted by the House of Delegates and referred to the Trustees. We recommend the composition of the districts as follows:

First District, Essex, Union, Somerset.
Second District, Hudson, Bergen, Passaic.
Third District, Morris, Sussex, Warren.
Fourth District, Middlesex, Monmouth, Ocean.
Fifth District, Mercer, Hunterdon, Burlington.
Sixth District, Camden, Gloucester, Salem.
Seventh District, Atlantic, Cumberland, Cape May.

CHANGE IN CONSTITUTION AND BY-LAWS

Increasing the Judicial Districts will necessitate several changes in the Constitution and By-Laws. It will be necessary to change the composition of the Board of Trustees by amending Article VI of the Constitution. Our recommendation is that the Board be composed of fifteen members as follows:

Six officers—the President, President-Elect, First Vice-President, Second Vice-President, Secretary, and Treasurer.

Seven members elected by the House of Delegates, one from each Judicial District, whose terms shall be for three years.

One member who shall be elected by and from the Fellows, and whose term of office shall be for three years.

The fifteenth member shall be the immediate Past-President, who shall be a member for one year without process of nomination and election.

The Committee on Constitution and By-Laws will formulate the necessary amendments, and present them to the Annual Meeting of the House of Delegates.

QUOTA OF DELEGATES

The matter of component societies electing, at their April or May meeting, additional delegates up to their paid-up membership, as it appears in those months, referred by the House of Delegates, has been considered. It is our opinion that this is not a good procedure; it is confusing and frequently gives a component society a greater representation the following year than it is entitled to. It is recommended that the By-Laws be amended so that the *Official List* shall be the basis of representation of delegates for the current year.

We recommend that if an elected delegate (except in case of illness) fails to attend two consecutive meetings of the House of Delegates—annual or special—he shall forfeit his seat.

NEW EXECUTIVE OFFICES

Because the entire building in which the offices of the Society were located was taken over by a chain-store, it became necessary to vacate the present offices before April first. Enlarged quarters—needed to care for the steadily increasing work at the central office—were leased in the Broad Street Bank Building, at 143 East State Street, and the Society moved into them on March twenty-third.

ASSISTANT TO THE EXECUTIVE OFFICER

The report and address of the President will presumably record in considerable detail the increasing activities of the Society, and its present and future responsibilities. The scope of the work will make plainly evident the necessity of employing an assistant to the Executive Officer. The Board proposes early in the new fiscal year to appoint one executive assistant—preferably a physician—as an aid to the Executive Officer. It is also likely that within a short time a second assistant will be needed.

IN MEMORIAM

It becomes our sad duty to record the recent passing of two distinguished members of the Society—both Past Presidents: Dr. John F. Hagerty, of Newark, and Dr. A. Haines Lippincott, of Camden. Both of these men gave long, honorable, and unselfish service to this Society.

Respectfully submitted,

Frederic J. Quigley, *Chairman.*

REPORT OF COMMITTEE ON CONSTITUTION AND BY-LAWS

To the House of Delegates:

The Committee on Constitution and By-Laws has met and has the following recommendations to offer for your approval:

CONSTITUTION

Article IV—*Composition of the Society;* Section 3—*Election of Delegates.* (d) Vacancies. Amend by inserting after the first comma on the fourth line the following words, "or fails to attend two consecutive meetings (annual or special) except in case of illness".

Article VI—*Board of Trustees.* Amend by striking out the entire first paragraph and substituting the following: "The Board of Trustees shall be composed of fifteen (15) members as follows: President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), one (1) member elected from each of the seven judicial districts, one (1) member elected by and from the Fellows, and the immediate Past President, who shall serve for a term of one year without process of nomination and election."

Article VI—*Board of Trustees.* Amend by striking out the entire second paragraph and substituting the following: "At the first election of officers following the adoption of this Constitution, two (2) members shall be elected for a period of one (1) year, two (2) members for a period of two (2) years, three (3) members for a period of three (3) years; and, as the terms of these elected Trustees expire, new elections shall be for periods of three (3) years each."

Article VII—*Councilors.* Amend by striking out the entire paragraph and substituting the following: "The House of Delegates shall organize seven (7) Councilor Districts within the State. This Society shall elect one (1) councilor from the membership of each such district; and these elected councilors, collectively, shall constitute the Judicial Council."

BY-LAWS

Chapter I—*Membership;* Section 2—*Official Lists of Members.* (a) Amend by striking out "February first" and substituting "March fifteenth".

(b) Amend by striking out "On the first day of February" and substituting "On the fifteenth day of March".

(d) Amend by deleting the semicolon on the sixth line and replacing a period. Also delete the remainder of this paragraph.

Chapter VII—*Judicial Council;* Section 1—*Election.* Amend by striking out the entire paragraph and substituting the following: "The Councilors shall be elected as follows: At the first election of officers following the adoption of these By-Laws, three (3) members shall be elected for a period of three (3) years; two (2) members for a period of two (2) years; and two (2) members for a period of one (1) year; and, as the terms of these elected Councilors expire, new elections shall be for periods of three (3) years."

Section 3—*Meetings.* Amend by striking out the last sentence in this paragraph and substituting the following: "Five members shall constitute a quorum."

Chapter IX—*Finance;* Section 3—*Fiscal Year.* Amend by striking out the word "June" and substituting the word "July".

Respectfully submitted,

Samuel Alexander,
Chairman
Wayne W. Hall
Joseph M. Kuder
H. H. Tyndall
Charles Bailey

REPORT OF THE COMMITTEE ON HONORARY MEMBERSHIPS

By Lancelot Ely, M.D., Somerville, N. J.

The Chairman has consulted each member during the year. No nominations for honorary membership have been recommended since the last State Society convention.

Respectfully submitted,

Lancelot Ely, *Chairman.*

REPORT OF THE SECRETARY

By J. B. Morrison, M.D., Newark, N. J.

The Secretary will present his annual report directly to the House of Delegates in the form of a supplementary report.

Respectfully submitted,

J. B. Morrison, *Secretary.*

REPORT OF THE PUBLICATION COMMITTEE

By HENRY C. BARKHORN, M.D., Newark, N. J.

To the House of Delegates:

The duty of the Publication Committee, according to the By-Laws of The Medical Society of New Jersey, Chapter VIII, Section 8, is to "publish and distribute the Journal".

The Executive Officer of the Committee is the Editor, who is a full-time employee of the Board of Trustees. The Editor has his offices in the headquarters of the Society, and is in contact with Executive Officer Wilkes daily, and relies largely upon him for advice regarding the interpretation of the formal reports and minutes of the officers and committees of the Society of the State and those of the counties. Every effort is made to print accounts of all projects of the societies. The result is that The Journal is the source on which the officers and members rely for information regarding official actions. While the minutes and reports are filed in the Executive Offices, their contents can always be found in The Journal in a condensed form, rewritten in order to insure brevity and clearness. Cross references are made to previous records, so that each volume of the Journal is in fact a complete record of the activities of the societies of the State and counties during the year.

EDITORIAL COMMENTS

A major function of the Editor is to prepare summaries of the activities of the societies and to correlate them in editorials and other comments, thereby establishing a unity of action and of objectives, with the avoidance of repetitions and overlapping of projects. The Journal is therefore an encyclopedia of information regarding every phase of Society work.

PREPARATION OF OUTLINES OF SUMMARIES

The editorial office is a center for the preparation of outlines and summaries for the use of the officers and committeemen. A special phase of that work has been the preparation of charts and lantern slides which the officers may use in explaining the activities of the Society. While the designing of the charts and slides, and their photography has devolved upon the Editor, he has been ably assisted in their execution by Miss Katz, and Miss Soden, of the staff of the Editorial and Executive Offices, whose skill in lettering is evident in the diagrams and in the lantern slides.

ILLUSTRATIONS

Special attention has been given to the illustrations of articles for The Journal. A close contact has been established with the artisans of the Trent Engraving Company, whose advice is always available so that the cuts shall be produced with the maximum of efficiency and clearness and economy.

It is the policy of the Publication Committee that illustrations shall be used as freely as possible. This is according to the custom of high-class periodicals generally. An example of the attractiveness which results from the free use of illustrations is the Journal of January, 1937, in which fifty-five cuts were used, all of which required the special attention of the Editor and the coöperation of the plate makers. Authors of scientific articles are always willing to bear the expense of making the plates for the illustrations of their articles, provided the results are artistic and clear. The thanks of the Society is due to the authors for their hearty coöperation in providing illustrations of an excellent quality.

COUNTY SOCIETY REPORTS

There has been an increasing response of the Reporters of the county societies in sending reports of their meetings. The September Journal carried a list of the regular meetings, 155 in number, of which 107 were reported as follows:

Atlantic	7
Bergen	8
Burlington	5
Camden	8
Cape May	2
Cumberland	5
Essex	7
Gloucester	8
Hudson	4
Mercer	6
Middlesex	7
Monmouth	8
Morris	9
Passaic	6
Salem	3
Somerset	5
Sussex	2
Union	5
Warren	2
	107

The county society reports sent to The Journal are a major source of information regarding new members and officers elected, and of actions on the projects of the State Society. The reports are printed with paragraph headings for ease of reference, and are indexed under classified activities, over two pages being required for the index of 1936.

Every effort is made to give each county society the recognition to which it is justly due.

REPORTING

Efficiency in editorial work depends largely upon the efficiency of the reportorial staff of The Journal. While the county reporters do their work efficiently and well, yet there is a need that their work shall be supplemented with data and suggestions secured by the visitations of the Editor to the several counties for the purpose of securing data and information of a broad nature. The Trustees authorized the Editor to visit the county societies, spending a day or two with each one in making a survey of the county-wide field, so that a summary of all forms of medical and health work may be presented in The Journal. Wherever this work has been attempted, it has been a revelation to the officers of both the State and local societies to find how many important activities go unrecorded. Moreover, the data presented in a tangible form is of inestimable value, revealing the wealth of activities for which no one receives credit.

The surveys were not carried out on a large scale for the reason that the time of the Editor was fully occupied in editing the "Handbook of Preventive Procedures", which was published as a supplement to The Journal of March, 1937.

A SUGGESTION

The Publication Committee suggests that the Editor be authorized to proceed with the surveys of the activities of the county societies and the opportunities for extending their sphere of influence in their local districts.

HANDBOOK OF PREVENTIVE PROCEDURES

The operation of the Federal Security Act revealed the need that the medical profession of New Jersey should consider the extent of the field of practice of preventive medicine which rightfully belongs to the Family Doctor, and in which he will be willing to engage when his attention is called to his opportunities.

The plan of the Handbook is founded on the method of medical practice for 100 years after the founding of The Medical Society of New Jersey in 1766, while the Family Doctor occupied all the field of the practice of medicine, and was the trusted adviser of all the members of the families of his patients in health as well as during sickness. We are prone to think of the old-time Family Doctor as working alone; but as a matter of fact, the neighbors of his sick patients were his unorganized assistants, and supplied the services of nursing and relief which are now left to organized agencies both official and lay, and social as well as medical. The time is now at hand when the Family Doctor shall assume his leadership as the medical adviser of all the other agencies engaged in the services of health, as was his predecessors for generations of time.

A prominent feature of the Handbook is the fifteen charts which indicate the relations of the Family Doctor to the other agencies that are engaged in supplying him and his patients with accessory services akin to those given by neighbors of the sick persons as occasion required a century ago.

Each chapter of the Handbook surveys the services which are rendered to the Family Doctor by accessory organizations in each field of medical activity.

The Handbook is an *index to procedures* rather than a *textbook of methods* of practice. It is, in fact, the first attempt of any medical society to set forth preventive medical procedures entirely from the standpoint of the Family Doctor.

The scope of the Handbook was unexpectedly extended from a projected plan of about twenty pages, so that sixty-eight pages were finally required to cover the field with some degree of completeness.

The suggestion of the Handbook originated with Dr. Stanley Nichols, Chairman of the Sub-Committee on Public Health, and was endorsed by the Welfare Committee, which provided the inspiration and the funds for preparing and publishing the work.

The contents of the chapters were derived from the discussions and reports of the several advisory committees and the sub-committees of the Welfare Committee, assembled into an entity by the Editor of The Journal, with the constant coöperation and advice of the one hundred or more members of the Welfare Committee, and its twenty-one subdivisions. The Handbook therefore represents the collective opinions of over one hundred leaders of the Medical Profession of New Jersey. It is to be expected that new and enlarged editions of the Handbook will be required from time to time as practicing physicians enter more and more into the spirit of the practice of preventive medicine.

HISTORICAL RESEARCH

The Publication Committee has given its hearty encouragement to historical research into the development of medical practice in New Jersey. While the importance of records is not usually realized at the time when they are made, their value becomes evident a half century after a project is initiated. It is surprising how the organization of The Medical Society of New Jersey has had a consistent development, with the new growing out of the old by a natural evolution. An example is that of the organization of the Board of Trustees and the Welfare Committee as described in an editorial on page 150 of the March Journal. This logical development was unexpectedly revealed after a search of an hour or two through the pages of the printed Transactions, beginning over a century ago.

SUGGESTIONS

The Publication Committee suggests that historical research be adopted as a continuing project of The Medical Society of New Jersey; and that the means be provided for making the investigations.

The committee further suggests that the Woman's Auxiliary be encouraged to assume the leadership in the historical research, and to present its results in its exhibit at each Annual Meeting.

The Publication Committee further suggests that a special committee be established, under whose auspices the historical investigations may be extended as a state-wide project. New Jersey is a rich field of opportuntiy that is unique among the medical societies of the several states. This field is of special importance in view of the national tendency to discard the old and adopt the new for the sake of its novelty. As a matter of fact, the physicians of 1788 were as wise and progressive as the statesmen who established the government of the United States on an enduring basis.

THE PRESENT JOURNAL

It is the purpose of the Publication Committee to make The Journal the repository of the records of not only the current activities, but also the aspirations of the far-seeing leaders in all branches of medical service. The Journal of the official year which is now closing reflects all lines of medical progress, because the organized medical profession is doing things more efficiently and on a broader basis than ever before. The editorial problem today is not how to obtain more original material; but what to decline, and how to condense the extensive record of what the Society is doing.

The Publication Committee thanks the officers and committeemen of both the State Society and the twenty-one component societies for their hearty response to requests for records of their progressive activities.

STATISTICS

Each year the Publication Committee has reported on the statistics of the contents of The Journal. The following table shows the number of pages in each department of The Journal during the year 1936:

	Editorials	Original Articles	State Society Activities	County Society Activities	Woman's Auxiliary	Advtg.
January	6	24	10	15	3	28
February	6	23	20	9	4	30
March	6	36	7	9	5	28
April	6	20	15	11	4	30
May	6	49	15	10	2	42
June	6	29	9	11	2	30
July	6	29	37	4	0	28
August	6	33	7	4	1	32
September	6	40	11	1	0	30
October	6	37	11	3	0	30
November	6	30	11	6	6	30
December	6	30	20	15	1	28
	72	380	173	98	25	366

Reading	746
Advertisements	366
Supplements:	
May, 1936, Official List of Members	60
August, 1936, Transactions of the House of Delegates and Woman's Auxiliary	72
Total Number of pages of The Journal in 1936	1246

These statistics do not differ widely from those of previous years. The standard *size* of The Journal would seem to be well adapted to the requirements of the Society and its members. However, there is no limit to the possible progress in the *quality* of its contents, and every effort will be made to adapt The Journal to the interests and the preference of the members, and to make it *their* Journal.

ADVERTISEMENTS

The number of advertising pages during 1936 was very nearly the same as those of 1935; but there has been a surprising increase in their number during the three months of 1937, as is shown in the following table:

	1937	1936	1935
January	36	28	30
February	40	30	28
March	44	28	28
April	66	30	38

The increase in 1937 has come largely from an increase in the number of local advertisers, especially private medical institutions, as the result of a return of prosperity.

FINANCIAL REPORT

June 1, 1936-March 1, 1937
(Fiscal year—from June to June)

RECEIPTS

Advertising	$ 7,185.33
Coöperative rebate	406.68
Journal copies	10.05
Extra subscriptions	45.90
Associate member subscriptions	375.75
Bills receivable	1,453.50
	$ 9,477.21

EXPENSES

Commissions	$ 1,747.30
Discounts	192.53
Bank maintenance charge	1.19
Printing and mailing of Journal	9,330.95
Reprints	111.75
Addressograph	19.31
Bad debts	17.00
	$11,420.03

SUMMARY

Amount of advertising secured by Coöperative	$ 3,636.00
Amount of advertising secured locally	3,549.33
Discount and commission allowed Coöperative	840.32
Discount allowed local advertisers	50.81
Commission paid local agents	1,038.70
Total amount of advertising	7,185.33
Total cash receipts, all sources	7,337.94
Amount sent to Treasurer (including $83.25 for special advertising in April)	6,298.05

DISTRIBUTION OF RECEIPTS

Dr. Elias J. Marsh, Treasurer	$ 6,298.05
Commission, local agents	1,038.70
Bank maintenance charge	1.19
	$ 7,337.94

Respectfully submitted,

HENRY C. BARKHORN, *Chairman*
EDWARD J. ILL
FRANK J. MCLAUGHLIN
SPENCER T. SNEDECOR, *Ex-officio*
J. BENNETT MORRISON, *Ex-officio*

REPORT OF THE JUDICIAL COUNCIL

By CHRISTOPHER C. BELING, M.D., Newark, N. J.

To the House of Delegates:

The Judicial Council has not had any matters of importance referred to it during the past year. Charges of unethical practice against a member of the Society was considered and disposed of. The Council found no cause for action after it received a satisfactory letter of explanation from the physician.

A protest dated September 30, 1936, by certain members of a County Society relative to a pending annual election in October, 1936, was considered. As the appellants had withdrawn their names from the ballot, and no protest had been received after the election, there was no action necessary on the part of the Council. The parties concerned were duly informed of the action of the Council.

A sample of a ballot used in the last annual election of the Hudson County Medical Society was inspected and it was noted that practically all of the suggestions offered by the Council in the decision rendered a year ago had been incorporated in the ballot.

Due to the early date of the State Meeting, it was decided that no District Councilor Meetings would be held this year. Because of the numerous meetings held by various active committees, meetings of the Welfare and Public Health committees, and the appearances of the Cabinet Members of the President before the various societies, some of the County Societies did not seem to favor the idea of District Councilor Meetings. The last few years these annual District Meetings have not aroused much enthusiasm. In view of the activities of the Welfare Committee and the offices of the Society, it is the opinion of the full Council that these District Meetings should be discontinued. This opinion of the Council was favored by the President of the Society.

The Judicial Council makes the following recommendations:

1. Redistribution of the Judicial Districts as suggested in its annual reports of 1934 and 1936.

2. Discontinuance of the annual district meetings.

Respectfully submitted,

CHRISTOPHER C. BELING, *Chairman*
W. J. SWEENEY
JAMES A. FISHER
CHESTER I. ULMER

REPORT OF THE COMMITTEE ON MEDICAL DEFENSE

By Christopher C. Beling, M.D., Newark, N. J.

To the House of Delegates:

During the past year, the Committee on Medical Defense, with the approval of the President, addressed two communications to the Component County Societies:

1. A request for coöperation of the County Societies by the appointment of Medical Defense Committees for the further development and organization of medical defense against suits.

2. An outline of the history, objects, and aims and operation of the State Society's medical defense and insurance plan.

COUNTY MEDICAL DEFENSE COMMITTEE

In response to our first communication, most of the County Societies have appointed committees, and our committee has already referred an important matter to one of the County Societies for investigation and action. We believe that the aid of these county committees will have a potent influence in binding the profession for its protection, and in keeping the members in line and responsive to their mutual responsibilities.

It is impossible in an annual report of this kind to set forth the problems connected with alleged malpractice defense, but it is strongly urged that every member of this Society, for his own benefit and that of the organized profession of which he is an integral part, will read carefully the article on "Insurance Against Alleged Malpractice" by Thomas V. McDavitt, of the A. M. A. Bureau of Legal Medicine and Legislation, published in the American Medical Association Bulletin, Vol. 31, No. 8, November, 1936.

In concluding his article, this writer, after citation of a few of the many factors involved in the problem of malpractice claims,—factors which must be taken into consideration in any study of the problem, or in any serious attempt on the part of the medical profession to reduce the frequency of such claims,—states that "some such attempt must be made to reduce the frequency of malpractice suits unless the medical profession is to resign itself to the present situation, or worse, of high malpractice insurance premiums and the possibility of higher premiums in the future, or, in some States, of having insurance companies withdraw from the field".

Your committee feels that the experience of The Medical Society of New Jersey, in this matter, is a favorable one, and that further coordinated effort should improve it greatly.

UNIFORMITY OF POLICIES

In July, 1936, there was a request made by the Newark Management of the Insurance Company asking for the coöperation of The Medical Society of New Jersey for obtaining the collateral business of its members. While this matter was under the advisement of the committee, a letter was received from Dr. Maurice Shapiro, Chairman of the Welfare Committee of the Hudson County Medical Society, stating that complaint had been made to the Hudson County Medical Society that the rates for insurance are not standard and uniform, and that the carrier is demanding other lines of insurance, or else they would not carry the physicians' liability policy.

Upon investigation it was ascertained that, while there was a request made for obtaining collateral business, it did not carry with it any proviso or mandatory condition.

It was unfortunate that this matter went through the hands of different agents and was not referred to the committee through our official agent or broker. The committee does not approve of the action taken in Hudson County by the representative of the Insurance Company, but it has no control over the situation, as the policy was not issued through the official broker of the State Society. To avoid confusion and discrimination in the future, it is advisable to have all matters relating to professional liability insurance directed to the State Committee on Medical Defense through the official broker, and to have him maintain records of all policies issued to members of the State Society.

COSTS OF INSURANCE

It is gratifying to report that the past year the number of claims were considerably less than the previous year. In 1935 there were 67 claims, but in 1936 only 44. Cost figures and other data will be given in a supplementary report.

While many companies have already withdrawn from writing this class of insurance, and rates have been increased considerably by those still in the field, the State Medical Society has had its insurance at much lower rates than those charged by other companies from the inception of the group plan sixteen years ago. This has been due to many factors, among which were the coöperation of the insured members in giving their services at little or

no cost in the preparation of cases, and in furnishing expert testimony at trials, and the steady growth of the membership. If the experience continues to be favorable, the committee hopes to obtain a reduction of premium rates.

The committee recommends the renewal of the present contract with the United States Fidelity & Guaranty Company of Baltimore through our present broker, Faulhaber & Heard, Inc., of Newark, N. J.

Respectfully submitted,

Christopher C. Beling,
Chairman
Edgar A. Ill
William Arlitz
Charles F. Baker
LeRoy Black

In order to explain the nature of the medical defense system of The Medical Society of New Jersey, the committee wishes to add the two communications to which reference is made in the first paragraph of this report. These communications are printed on page 281.

REPORT OF COUNCILORS

FIRST COUNCILOR DISTRICT

WARREN, UNION, MORRIS AND ESSEX COUNTIES

By Christopher C. Beling, M.D.,
Newark, N. J.

To the House of Delegates:

During the past year no matters of any ethical or judicial character were referred to the Councilor. Some inquiries were made regarding questions of advertising.

The component societies of this district have maintained a high standard of scientific work, and through committees have carried on activities along public health and other lines. These activities have been already chronicled in the Journal by the Reporters. No annual District Councilor Meeting was held this year, as there did not seem to be an urgent demand for it, after the President's program covering the socio-economic and other phases of the work of the State Society had been presented to the societies.

I wish to take this opportunity to thank the Essex County Medical Society for its courtesy in reserving a date in March for the Councilor Meeting.

Christopher C. Beling.

SECOND COUNCILOR DISTRICT

SUSSEX, BERGEN, PASSAIC AND HUDSON COUNTIES

By William J. Sweeney, M.D.,
Weehawken, N. J.

To the House of Delegates:

There have been a decrease in malpractice suits in this district due, no doubt to the ever increasing care on the physicians part.

The rank and file of the profession, due to the reiteration of the Journal and State Officers, are beginning to realize that a mighty change has come over the practice of medicine and greater changes are in the offing.

The physician must be militant in protecting his rights; and if he can not give of his time, as so many do, then he must be prepared to keep furnishing the funds so that those who labor in his behalf can carry on the work.

Few complaints have been received,—in general the errors are those of omission and inertia rather than commission.

Wm. J. Sweeney.

THIRD COUNCILOR DISTRICT

MERCER, MIDDLESEX, SOMERSET AND MONMOUTH COUNTIES

By Frank G. Scammell, M.D.,
Trenton, N. J.

To the House of Delegates:

The activities of the third district have progressed along normal lines. There have been no internal dissentions among the members, requiring the advice or assistance of the Third District Councilor.

Frank G. Scammell.

FOURTH COUNCILOR DISTRICT

CAMDEN, BURLINGTON, OCEAN AND MONMOUTH COUNTIES

By James A. Fisher, M.D.,
Asbury Park, N. J.

To the House of Delegates:

I have been in contact with the secretary of each of the component societies comprising the Fourth District, and am pleased to report that there are no cases of contemplated malpractice suits against any members of the society.

The Judicial Council has been called on to investigate one instance of alleged unethical practice, but the report has been forwarded to the State Officers.

James A. Fisher.

FIFTH COUNCILOR DISTRICT

ATLANTIC, CAPE MAY, CUMBERLAND, GLOUCESTER and SALEM COUNTIES

By CHESTER I. ULMER, M.D., Gibbstown, N. J.

To the House of Delegates:

This is my first report as a member of the Judicial Council. I have made official visits this year to all of the County Societies in the Fifth Councilor District except Cape May, and I appreciate the cordial reception extended to me at these meetings.

The Councilor has urged each County Society in the Fifth District to encourage the attendance of its delegates at the meetings of the other Societies in the District. This will not only promote a spirit of fellowship among the component Societies, but it will also tend to increase the solidarity of our State organization.

The Councilor has had correspondence with two of the County Societies in the Fifth Councilor District concerning problems of an ethical nature involving two members. Both matters have been adjusted.

The work has been most enjoyable through out the year.

CHESTER I. ULMER.

REPORT OF THE COMMITTEE ON INSURANCE

By FRANK W. PINNEO, M.D., Newark, N. J.

To the House of Delegates:

This report covers eleven months from March 1, 1936, to February 1, 1937,—a month less than the year because of the early date of this convention.

THE ACCIDENT AND HEALTH INSURANCE

This is a group policy with the National Casualty Company, and is the very contract originally negotiated by us years ago after a thorough study of many standard policies, with special features adapted to the needs of the average doctor's life and at a premium so reasonable all our members would want to pay. And these features have been added to, e. g., covering travel by air (originally not done) and increasing the time for disability not house-confining,—all without any increase of premium. Other advantages we are keenly watching to add as fast as the number taking the policy increases to warrant it. There are 272 policy-holders distributed as follows:

Atlantic	5
Bergen	30
Burlington	5
Camden	18
Cape May	5
Cumberland	4
Essex	73
Gloucester	6
Hudson	18
Hunterdon	4
Mercer	16
Middlesex	7
Monmouth	9
Morris	16
Ocean	3
Passaic	15
Salem	3
Somerset	5
Sussex	2
Union	25
Warren	3
	— 272

This includes an increase, for the period, of 23, and a decrease of 25.

DISTRIBUTION BY AGE GROUPS

Ages under 50	167
51 to 60	66
61 to 65	26
66 to 70	13
	— 272

CLAIMS PAID

Ages under 50—	23 claimants	$2,466.04
50 to 60—	9 claimants	2,485.68
60 to 65—	2 claimants	121.43
66 to 70—	5 claimants	778.56
		$5,851.71

These claims ranged from $25.00 to $1,374.99 each.

Gross premiums received in the eleven months, $15,902.64.

Loss ratio, 37 per cent, which will be increased in closing pending cases.

For accidents, benefits are for 52 weeks' total and 26 weeks' partial disability, and for travel accidents the indemnity is doubled.

For illness, benefits are for 52 weeks' total, house-confining, and six weeks, non-house-confining, disability.

The policy may be written for $50 or $25 weekly benefit, and at annual, semi-annual, or monthly premiums.

The service, through the Blanksteen Agency, has been very satisfactory and proves that cas-

ualty insurance need not depend on technicalities evading responsibility.

The company is classed as an "A plus" company, and we note that it ha sassets of $1.95 for every $1.00 of liabilities, a record equalled by only a very few companies.

AUTOMOBILE INSURANCE

In automobile insurance we have progressed further in developing the *service* for members on claims against "the other party" in an accident. These cases are damages not covered by insurance but claimed against "the other party", and are difficult to collect because they involve investigation, expense, and perhaps legal action; and victims neglect pushing their claims, which, however, are mostly collectable. During the eleven months of this report this service for claims totaling $2,960 has been given to eighty-three members. It cost them nothing. The agency's expense for attorney's fees was $1,080.95. In the preceding twelve months similar collections amounting to $3,669 were recovered for twenty-four members. This was equal to the State Society dues at $13 each for 282 members or $1.30 for every member. This service has so grown that we had to find means to legalize it, and have arranged to offer our members at the special fee of one to three dollars (according to territory), without other obligations, membership in the Automobile Association of New Jersey. Other esrvices are incidentally included.

Utmost choice of company is given every member, the responsibility of selection being his alone, the Society recommending none. We have sundered all connections with former companies, and for months have not recommended them. And the agency is entirely new. The Physicians' Underwriting Agency represents only "A plus" companies, and they will give a bond to secure our members for every service rendered and funds handled.

Number of doctors insured, including increase of 51 and decrease of 53	1241
Total premiums written	$37,735.48
Premiums earned	18,735.48
Claims paid by Casualty Company	1,082.43
Claims reserved for payment by Casualty Company	1,009.00
Claims paid by Fire and Theft Company	150.65
Claims against others (collected or pending)	2,960.92
Agency's expense for attorney's fees for collections	1,080.95

We believe we have now perfected arrangements to:

1. Obviate the Society having any responsibility—moral or financial—for the selection of any company.
2. Render service of widest range, including collection of claims against the "other party", and other advantages.
3. Afford perfect security for everything.
4. Grant group advantages to those who choose, without putting any burden or obligation on other members or the Society.

We suggest recommendation by the Society.

This report concludes with the following report made to the Board of Trustees:

To the Board of Trustees, Medical Society of New Jersey:

The Committee on Insurance wishes to submit the following report, which is confined to two forms of insurance: (1) Health and Accident Insurance, and (2) Automobile Insurance:

HEALTH AND ACCIDENT INSURANCE

The present group policy contains definite advantages which cannot be obtained by physicians as individuals. To enumerate:

1. A lower premium is possible due to the collective bargaining power of the group, since the company saves in expense, notably that of soliciting.
2. Arbitration of any disputed claim lies with the Committee on Insurance of the State Society, and the company abides by the decision of the committee.
3. Cancellation of policy during the term, one year, cannot be made by the company, whereas the customary individual policy can be cancelled by a company any time.
4. Our age limit in this policy is seventy, which is ten years beyond the customary age limit for health insurance in other policies.
5. A short form of application is permitted our members, whereas the form required by companies for individual policies is at least two and a half times as long, and the extra questions, being more searching as to the applicant's past medical history, result in more persons being denied insurance than under the short form.

For this policy your committee has selected the National Casualty Company of Detroit, whose rating is "A plus" (the very highest). We are well aware of the fact that during the past decade certain companies with a rating of "A plus" have failed, and that, should a similar financial crisis recur, this might happen again. In 1933, due to the failure of the International Re-insurance Corporation, five of our members suffered loss of their claims totaling $1,200. Offsetting this, however, the prompt securing by the Blanksteen Agency of

the present company to carry the insurance without new premiums for the year saved about $6,000 in premiums to our members, and thirteen of them collected claims the following year.

We would call attention to the fact the risks assumed by the insured are the same whether as individuals or as a group; but there are definite advantages in a group which cannot be obtained as individuals.

At a meeting of this committee on January 3rd, 1937, a motion made by Dr. Okin and seconded by Dr. Bloom, was unanimously carried recommending to the Trustees of the State Society the continuance of the present set-up of health and accident insurance as now in operation, and secondly, that the Trustees recommend that the county societies afford the Blanksteen Agency occasional opportunities to present to their members this form of insurance.

A specimen of this policy is enclosed.

AUTOMOBILE INSURANCE

In this insurance legal restrictions govern the premiums, which must be the same to individuals or to members of a group. But in *service* we can obtain advantages as a group which are utterly impossible to an individual. Notable among these is help in case of claim against the *other* party in an accident. We submit herewith for your consideration an offer to us from the Physicians' Underwriting Agency of services for collecting such claims and which also includes other advantages.

The committee recommends:

1. That the responsibility for selection of insurance company rest solely with the applicant for insurance himself.

2. That the selection and application for automobile insurance be made through a Central Office or Bureau, to be chosen by the Committee on Insurance.

3. That in consideration of the volume of business offered, the committee secure a list of specified services offered to the group by the Central Office, as the basis of an agreement.

4. That to fully protect every applicant for insurance in dealing with the Central Office, the latter shall, at its own expense, be bonded for $5,000 by a responsible Bonding Corporation, although if payments for insurance premiums are made to the name of the underwriting company bonding the agent is superfluous.

We also suggest that the Trustees recommend to the County Societies that they offer occasional opportunities for the Central Office to present to the members this form of insurance.

After considering propositions from others for service on the lines indicated, the committee recommend unanimously that an agreement be made with the Physicians' Underwriting Agency as per the attached form. This includes a certificate and statement of the Automobile Association of New Jersey necessary to legalize the service.

Respectfully submitted,

Frank W. Pinneo, *Chairman*
Lawrence Bloom
Edmund N. Huff
Joseph W. Hurff
Irving Okin
Thomas J. Summey
Albert J. Ward
E. Zeh Hawkes

REPORT OF THE A. M. A. DELEGATES

By John F. Hagerty, M.D., Newark, N. J.

The report of the meeting of the House of Delegates of the American Medical Association held in Kansas City, May 11 - 15, 1936, was presented to the House of Delegates of The Medical Society of New Jersey on June 2, 1936, and was published in The Journal of June 1936, page 367. Since the next meeting of the A. M. A. will be held in Atlantic City on June 7 - 11, the Delegates will not make a report at our own annual meeting.

John F. Hagerty,
Chairman of Delegates.

This report was received on January 19, a week before Dr. Hagerty's sickness and death.

POST-GRADUATE EDUCATION

It is impossible to render a report of the work of the Committee on Post-Graduate Education at this time. A full, but concise, report will be presented as a supplementary report at the Annual Meeting.

Respectfully submitted,

Harry H. Satchwell, *Chairman.*

REPORT OF THE COMMITTEE ON PROGRAM AND ARRANGEMENTS

By Charles B. Kaighn, M.D., Atlantic City, N. J.

To the House of Delegates:

The Committee on Program and Arrangements has endeavored to meet the wishes of all those to whom are assigned the duty and honor of providing the various contributions and activities which go to make up the program of the 171st annual meeting of The Medical Society of New Jersey. The Committee members express their thanks for the fine spirit shown by those in charge of the special programs in coördinating the component parts into a program of unity and balance.

The Scientific and Technical Exhibits are larger than ever. By courtesy of the Haddon Hall Management who are always most coöperative, a new layout to bring together as compactly as possible all the activities of the meeting is being tried out.

The meetings and papers are definitely scheduled as to time and place, and will be delivered on the announced time. The Committee on Program and Arrangements especially requests that committees assigned to designated rooms at a stated time, use these rooms at the hour scheduled, for the rooms are to be used by several groups, and are available to each committee only at the scheduled time. The only purpose of dispatching all meetings on scheduled time is to prevent confusion, and provide a smooth and harmonious meeting for all those in attendance. The coöperation of everyone is earnestly solicited.

In the Bureau of Information stenographic and clerical assistance will be available for the use of Chairmen in the preparation of the reports of the Reference Committees .

Respectfully submitted,

Charles B. Kaighn, *Chairman*
D. Ward Scanlan
John W. Gray
Spencer T. Snedecor, *Ex-Officio*
J. Bennett Morrison, *Ex-Officio*

REPORT OF THE COMMITTEE ON SCIENTIFIC WORK

By Louis Lange, M.D., Weehawken, N. J.

To the House of Delegates:

The Committee on the Scienitfic Program of the Annual Meeting has endeavored to provide speakers and subjects of special interest to the members, and to select subjects of appeal to the general practitioner whose work covers a broad field.

The specialists' interests are also intensively covered in the section programs. The printed program speaks for itself .

How well the committee has accomplished its aims and purpose must be judged by those attending the Annual Meeting. The committee wishes to thank those who are contributing to the Scientific Program, for without their fine spirit of coöperation the program would not have been possible.

Respectfully submitted,

Louis Lange, *Chairman*
Robert S. Gamon
Clarence L. Andrews

REPORT OF THE SPECIAL COMMITTEE ON SCIENTIFIC EXHIBITS

By Asher Yaguda, M.D., Newark, N. J.

To the House of Delegates:

The Committee on Scientific Exhibits during the past year has endeavored to keep before the members of The Medical Society of New Jersey the value of the Scientific Exhibits. To this end there have been published in the Journal pictures of the 1936 exhibits, and short summaries of the lessons brought out by each. We hope the results of this program will be evidenced in an increased attendance at the Annual Meeting.

As a result of visits to several of the larger medical society conventions, and by invitations to individuals who have contributed new thoughts to the various branches of the practice of medicine, we have applications for space from fifty-two exhibitors, as shown in the annexed list. We anticipate an excellent scientific exhibit, full of meaty lessons on timely subjects.

PUBLICATION OF PROCEEDINGS

We recommend that action be taken by the proper officers or committees to insure the future publication of the proceedings of the Scientific Exhibits each year. This not only will bring valuable information to the membership of the society, but will serve as a medium for publicity for the coming annual meetings. During the past year publication was only possible because of the excellent cooperation of the Editor of the Journal, Dr. Frank Overton. The committee believes that action as recommended above would relieve the Editor of responsibility for publication of material which adds to the expense of the Journal.

AWARDS OF MERIT

The Board of Trustees recently approved an appropriation for the presentation of awards for scientific exhibits of exceptional merit. These awards, six in number, will be presented for the first time at the 1937 session. The committee recommends that the giving of awards for scientific exhibits be made a permanent part of the scientific exhibit each year, because of their value in stimulating the preparation of better exhibits for presentation at the Annual Meeting. The committee recommends that future Committees on Scientific Exhibit continue as permanent features of the exhibits:

1. The fresh pathology exhibit.
2. The publication of photographs and summaries of the better exhibits in the Journal.
3. The presentation of awards.

A list of the Scientific Exhibits for 1937 is appended to this report.

Respectfully submitted,

Asher Yaguda, *Chairman*
William J. Marquis
Robert A. Kilduffe
Carlos A. Pons
Harrison S. Martland
John W. Gray
Elwood E. Downs
Harry J. Perlberg

LIST OF SCIENTIFIC EXHIBITS FOR THE 1937 SESSION

BOOTH NUMBER 1

Cardiovascular-Renal Diseases
Metropolitan Life Insurance Company, New York City

2

Medical-Dental Service Bureau of Essex County, Essex County, New Jersey

3

Plastic Surgery
Dr. Lyndon A. Peer, Newark Eye and Ear Infirmary, Newark, N. J.

4

Forensic Application of Blood Groups
Drs. Philip Levine, E. M. Katzin, Beth Israel Hospital, Newark, N. J.

5

Aetna Highway Safety Demonstration
Aetna Casualty & Surety Company

6

Subdiaphragmatic Abscess
Drs. W. W. Maver and Charles Oderr, St. Vincent's Hospital, New York City; St. Francis and Christ Hospitals, Jersey City, N. J.

7

Abnormalities and Plastic Surgery of the Lower Genito-Urinary Tract
Dr. Hugh H. Young, Johns Hopkins Hospital, Baltimore, Md.

8

General Pathologic Exhibit
Dr. M. J. Fein, Mountainside Hospital, Montclair, N. J.

9

The Diversified Clinical Picture Produced by the Failing Ovary
Drs. Rita Finkler and Milton Friedman, Newark Beth Israel Hospital, Newark, N. J.

10

Endometrial Biopsies, Studies of Normal and Abnormal Phases
Dr. Daniel R. Mishell, St. Mary's Hospital, Orange, N. J.

11

Prepituitary, Female and Male Sex Hormone Assays; Their Clinical Significance
Drs. Robert T. Frank, Morris A. Goldberger, U. J. Salmon, Gertrude Felshin, Emanuel Klempner, The Mount Sinai Hospital, New York City

12

Thoracoplasty in the Treatment of Tuberculosis
Dr. Joseph P. Morrow, Bergen County Hospital, Ridgewood, N. J.

13

The Danger of the Unrecognized Case of Tuberculosis as a Carrier of the Disease in High Schools and Colleges
Dr. Abraham E. Jaffin, Hudson County Tuberculosis Clinics, Jersey City, N. J.

14

Your Own Prescription,—Ask About It!—The New Jersey Formulary
Joint Committee on Professional Relations of the New Jersey Medical Society and the New Jersey Pharmaceutical Association

15

The Treatment of Gonorrhea in Women by Means of a Combined Heating Technic
Dr. William Bierman, Dr. E. A. Horowitz, Mount Sinai Hospital, New York City

16

Neoplasms of the Female Generative Organs
Dr. S. A. Goldberg, Presbyterian Hospital, Newark, N. J.

17

The Roentgenkymographic Examination of the Heart, a method of graphically recording the cardiac movement by the x-ray
Dr. I Seth Hirsch, School of Medicine of New York University, New York City

18

Pleural Adhesions Complicating Pneumothorax Therapy
Dr. J. W. Cutler, Henry Phipps Institute, University of Pennsylvania, Philadelphia, Pa.

19

Untreated Syphilis in the Male Negro; a Comparative Study of Treated and Untreated Cases
R. A. Vonderlehr, Assistant Surgeon General, Division of Venereal Diseases, U. S. Public Health Service, Washington, D. C.

20

Syphilis, Labortory Diagnostic Aids
Dr. A. J. Casselman, Bureau of Venereal Disease Control, State Department of Health, Trenton, N. J.

21

Kline Tests for the Detection of Syphilis
Dr. Charles Robert Rein, New York Post-Graduate School and Hospital of Columbia University, New York City

22

Clinical Laboratory Methods, Electroscopometry
Drs. W. G. Exton and Antin R. Rose, Prudential Insurance Co., Newark, N. J.

23

Fresh Pathology Exhibit
Various Pathologists

24

Peripheral Vascular Disease, Treatment by Intermittent Venous Occlusion
Drs. William S. Collens and Nathan D. Wilensky, Israel Zion Hospital, Brooklyn, N. Y.

25

Vascular Studies
1. Treatments of Varicose Ulcers by Choline Salts
2. Tissue Extract in Peripheral Vascular Disease
Dr. Joseph Wiener, Post-Graduate Hospital and Medical School fo Columbia University, New York City

26

Thrombo-angiitis Obliterans
Dr. Samuel Silbert, The Mount Sinai Hospital, New York City

27

The Use of Enzyme-free Pancreatic Tissue Extract in the Treatment of Angina Pectoris and Arteriosclerotic Cardiovascular Disease
Drs. Joseph B. Wolffe and Victor A. Digilio, Temple University, Philadelphia, Pa.

28

Electrocardiographic Abnormalities in Clinically Normal Individuals
Drs. L. S. Ylvisaker and H. B. Kirkland, Medical Department, Prudential Insurance Company, Newark, N. J.

29

Results of Electrosurgical Operation for Advanced Carcinoma
Dr. Tibor deCholnoky, Post-Graduate Medical School and Hospital, Columbia University, New York City

30

Tumors of the Brain
Dr. Frank W. Konzelmann, Temple University Medical School, Philadelphia, Pa.

31

The Medical Society of New Jersey
Executive Offices, Trenton, N. J.

32

Pollinosis
Dr. Warren T. Vaughan, Richmond, Va.

33

Hypertrophy of the Prostate
Dr. Charles F. Geschickter, Surgical Pathological Laboratory, John Hopkins Hospital, Baltimore, Md.

34

Endoscopic Resection of the Prostate, Gross and Histopathologic Study, Demonstration of Instrumental Technic
Dr. Samuel E. Kramer, Perth Amboy and Newark, N. J.

35

Diseases of the Blood
Drs. Roy R. Kracke and Hortense Garver, Emory University, Ga.

36

The Effects of Irradiation on the Normal Blood Cells as Determined by the Blood Count
Dr. Karl Kornblum, Fred Boerner, V.M.D., Samuel G. Henderson, Graduate Hospital, University of Pennsylvania, Philadelphia, Pa.

37

Anilin Tumors of the Bladder
Drs. Washburn, Gay and Ferguson, Carpenter Memorial Clinic, Wilmington, Delaware

38

Fractures About the Elbow
Dr. Irwin E. Siris, Fourth Surgical Division, Bellevue Hospital, New York City

39

Trauma of the Kidney
Dr. W. Calhoun Stirling, A. M. Lands, Ph. D., Georgetown University School of Medicine, Washington, D. C.

40

Experimental Radium Poisoning
Drs. Maurice Rosenthal, and Edwin J. Grace, Department of Pathology, Long Island College of Medicine, Brooklyn, N. Y.

41

Cardiac Resuscitation, a Study of Accidental Electrocution
Drs. Albert S. Hyman, J. Sante Diasio, Charles Hertzman, Witkin Foundation for the Study and Prevention of Heart Disease, Beth David Hospital, N. Y. C.

42

Traumatic Injuries, Prevention and Repair, with Special Reference to Head and Neck
Dr. Jacques W. Maliniak, Newark, N. J.

43

Rehabilitation of the Disabled
Dr. Henry H. Kessler, New Jersey Rehabilitation Commission, Newark, N. J.

44

Pneumoconiosis, An Industrial Disease
Drs. Edgar Mayer, Sidney Greenberg, Martin Dworkin, New York City

45

Tuberculosis Case Finding Among Nurses
Drs. Berthold S. Pollak and Samuel Cohen, Jersey City Medical Center, Jersey City, N. J.

46

Tumors of the Gastro-Intestinal Tract
Dr. A. Hobson Davis, Paterson General Hospital, Paterson, N. J.

47

Hemorrhage in Obstetrics,—Congenital Malformation of the Heart
Drs. S. A. Cosgrove and N. M. Alter, Margaret Hague Maternity Hospital, Jersey City, N. J.

48

The Visualization of the Reticulo-Endothelial System, with Special Reference to Silicosis
Dr. Raphael Pomeranz, Newark, N. J.

49

Interesting and Unusual Obstetrical Radiographs
Dr. Harry J. Perlberg, Margaret Hague Maternity Hospital, Jersey City, N. J.

50

Pathology in Diseases of Petrous Apex
Dr. Wells P. Eagleton, Newark Eye and Ear Infirmary, Newark, N. J.

51

Epilepsy and Endocrinopathies
A. W. Pigott, Roentgenologist, N. J. State Village for Epileptics, Skillman, N. J.

52

Unusual Gastro-Intestinal Cases
Dr. George S. Reitter, Orange Memorial Hospital, Orange, N. J.

MOTION PICTURE THEATRE

DAILY PROGRAM

9:30 a. m. & 2:30 p. m.

I. The Technic of Electrosurgery in Advanced Carcinoma
1. Recurrent Rectal Carcinoma
2. Recurrent Carcinoma of the Ear with Bone Iinvolvement
Dr. Tibor de Cholnoky, New York City

10:00 a. m. & 3 p. m.

II. Standard Obstetrical Routine
Dr. Lyle G. McNeile and Donald G. Tolefson, Los Angeles, California

11:20 a. m. & 4:20 p. m.

III. The Treatment of Gonorrhea in the Female by Means of Systematic and Additional Pelvic Heating
Dr. William Bierman, New York City

11:35 a. m. and 4:35 p. m.

IV. Opportunity—A sound film
Dr. Henry H. Kessler, Newark, N. J.

REPORT OF THE WELFARE COMMITTEE

By Hilton S. Read, M.D., Atlantic City, N. J.

To the House of Delegates:

The Welfare Committee during the current year has held five meetings. The following major considerations have been discussed and acted upon:

Public Health Coöperation
Pure Food and Drug Legislation
Preventive Medicine Handbook
Cancer Survey, and Projects for Cancer Control
Tuberculosis Control
Venereal Disease Control
Maternal and Child Health Programs
Crippled Children's Program
Speakers' Bureau
Middlesex County Plan
Medical Relief of Indigents Plan
Public Relations Program
Baby Keep-Well Stations
Graduate Education
Organized Effort Through Medical Societies
Paternity Blood-Grouping Test
Legislation (Federal and State)
Package Library for Speakers
Annual Meeting Program Suggestions
Health Weeks
Ethical Publicity
Increased Membership Drive
Pharmaceutical Problems
Contract Practice
Workmen's Compensation
Nursing and Nursing Education
Medical Practice
Health Insurance Plans
Hospital Insurance Plans
Woman's Auxiliary Functions

Most of these problems have first been carefully considered by one or more of the subcommittees and the advisory committees directly concerned. These committees then presented their recommendations for the criticism of the Welfare Committee members before a final vote thereon was taken by the Welfare Committee and recorded in the minutes.

Records of these discussions and recommendations have appeared from time to time in The Journal, and are also reported back verbally to the county society members by the members of the Welfare Committee.

In addition to the appointed members, the officers of all the county medical societies are invited to attend and participate in the meetings of the Welfare Committee.

Progress reports on county society programs and activities are made verbally to the Welfare Committee by county society representatives from time to time. This information and the constructive suggestions for the improvement of the State Society program and activities are always welcomed; and when approved by the majority of the members, are sent on to the Board of Trustees for their approval.

This year all chairmen of advisory committees were made members of the Welfare Committee, thereby giving better integration of committee programs.

The meetings were well attended, and great interest and activity were manifest at each meeting. As Chairman, I wish to thank each member for his faithful discharge of assigned tasks, and to congratulate the Society upon its selection of you as a member of this important committee.

The detailed annual reports of the subcommittees and advisory committees are submitted, and these reports appear in the April Journal.

Members of the Society are invited to appear before the various reference committees at the Annual Meeting to express their views on any of the subjects discussed in these annual reports.

Respectfully submitted,

Hilton S. Read, *Chairman.*

REPORT OF THE SUB-COMMITTEE ON PUBLIC HEALTH

By Stanley Nichols, M.D., Asbury Park, N. J.

To the Welfare Committee:

The tremendous avalanche of new public health problems presented to The Medical Society of New Jersey during the past year, particularly those in connection with the Federal Funds from the Social Security Act, along the following lines: Maternal Health, Child Health, Crippled Children, Venereal Disease Control, Tuberculosis Disease Control, The Blind, and Public Health Administration, all of which involves the delivery of certain amounts of medical service by physicians, has made the past year an overwhelmingly crowded one for the Public Health Committee, the officers of the State Society, the State Advisory Committees, and the County Public Health Committees, because of the complexity and difficulty of dealing with the problems presented, in such a way as to continue the increasing assumption of responsibility for county and state community health on the part of the County and State Medical Societies.

A great deal of progress in many of the fields of *Preventive Medicine* has been made during the past year; but even greater progress must be made during the crucial year which lies directly ahead of us.

The work and progress of the County and State Medical Societies of not only New Jersey but the other states of the Union, during the year 1937 and 1938 toward assuming health responsibilities, will unquestionably decide for some years to come what the private practice of the future is to become.

We are faced with the possibility of Federal Health Insurance, and challenged with tremendous problems in every field of public health, and we are proud to report that The Medical Society of New Jersey is one of the leaders among the state societies who are organized and successfully working in both economic, legislative and public health groups to preserve the private practice of physicians, and at the same time assume as an organized medical group, full responsibility for the health of all of the citizens of its state. Never before in the history of this country have such health challenges been laid down by social, welfare, political, and economic groups, and our successful progress during the year to come will depend on the keen loyalty of every member of The Medical Society of New Jersey.

It can no longer be said, as it was said five years ago, that the field of Preventive Medicine is rapidly slipping from the grasp of both the individual physician and organized medicine; and the strenuous efforts of all the physicians (and there are now over 200 of our State members in this group) working on the Public Health Committees, Advisory Committees, County Public Health Committees, and other special health committees, have been directed toward the definite assumption of responsibility in every field of Preventive Medicine, both in each county and in the State of New Jersey.

Our *Public Health Committee* formulated its program early in the Fall of 1936, and has met regularly on the first Wednesday of each month at the Academy of Medicine in Newark to act as a clearing house for the recommendations of the Advisory Committees and to consider the problems of the public health committees of the county societies, and particularly the health problems involved in the setting up of the use of Federal funds under the Social Security Act for better public health.

The Advisory Committees, as will be shown by their appended reports, have worked conscientiously and vigorously for these various health objectives during the past year; and I wish at this time to offer the thanks of the State Society and our committee to all of the physicians and laymen who have aided us in the heavy task we have attempted to carry during the past year, and particularly the members of the committee itself, the chairmen and members of the Advisory Committees—Committee on Cancer Control, Dr. Henry B. Orton, Chairman; Committee on Maternal Welfare, Dr. Arthur W. Bingham, Chairman; Committee on Venereal Disease Control, Dr. C. H. deT. Shivers, Chairman; Committee on Mental Hygiene, Dr. James S. Plant, Chairman; Committee on Tuberculosis, Dr. B. S. Pollak, Chairman; Committee on Child Health, and Committee on Crippled Children, Dr. Elmer P. Weigel; the State Board of Health and its personnel, particularly Dr. Irving Diebert, President of the Board; Director J. Lynn Mahaffey, and Mr. William Macdonald, Chief of the Bureau of Local Health Administration; Dr. Julius P. Levy, Chief of the Bureau of Maternal and Child Health; Dr. Arthur J. Casselman, Chief of the Bureau of Venereal Disease Control; the officers and committees of the New Jersey State Parent-Teacher Association, the Health Officers' Association, the Public Health chairmen and members of the

County Public Health Committees of the County Medical Societies, the advisory members from the State Department of Institutions and Agencies, the Department of Education, the State Tuberculosis League, the State Crippled Children's Commission (Mr. J. Buch, President), the various official and non-official health agencies who have assisted our county and State societies in solving these health problems, and the many other physician members and lay persons who have participated in a most helpful way in the efforts of our committee to carry the heavy load placed on us continuously during the year just past.

THE 1936-1937 PROGRAM

Our program, outlined in September, 1936 (Jour., Sept., p. 596), and adopted by the Welfare Committee, was concentrated on two specific accomplishments,—the first, to make definite further progress toward the bringing into being of the realization of our slogan—*"To make every physician's Office in New Jersey a Health Center for the practice of all phases of preventive medicine"*.

Our second objective was to assist the County Medical Societies in their development of practical plans whereby preventive medical service by their member physicians could be actually made available to the peoples (at all economic levels) in each county by two possible methods:

a. As far as possible in the offices and private practices of its physician members;

b. By each County Society, in conjunction with the Health Departments and other health agencies, creating specific plans whereby people not served privately for economic reasons could be offered complete preventive medical services.

In brief, this meant that our committee would try to assist both the individual physician's *private practice* of preventive medicine, and the County Medical Society's organized *Public Health practice* of preventive medicine for each entire county as a community.

In order for an individual physician or a county society to successfully practice preventive medicine, it was recognized that three essential steps were necessary; and it has been the continued effort of our committee to bring into concrete being the essential factors in these three steps.

FIRST STEP—THE HANDBOOK OF PREVENTIVE PROCEDURES

The first step necessary is that a printed outline be furnished every member of our State Society of Suggested Procedures in each of the fields of preventive medicine, to give our members aid and assistance in improving the development of preventive medicine in their private practices. Such printed suggestions have been prepared by the work of the Advisory Committees and officers of the State Society; and through the able efforts of Dr. Overton, Editor of the State Journal, have been compiled, printed, and published as a supplement to the State Journal. This Handbook, while necessarily incomplete, is a definite forward step in the gradual crystallization of practical assistance to our members by able fellow physicians in each of the fields of preventive medicine in private practice. It is the sincere hope of our committee that this Handbook will be of very real value to each of our members during the years to come.

SECOND STEP—POST-GRADUATE EDUCATION

The second essential step, after outlining the field, is that frequent and continuous *Post-Graduate Education,* both didactic and clinical, be made reasonably available to every physician and member of The Medical Society of New Jersey, with special attention to the fields covered by the Handbook on Preventive Medicine.

In addition to the efforts of County Societies and various groups along this line, we have been able, by the coöperative assistance of the State Department of Health, to offer considerable Post-Graduate Education, utilizing Federal funds.

Dr. Bingham's Committee on *Maternal Health* has given didactic courses covering its field, and has sent out Field Physicians with helpful literature and suggestions from the State Maternal Welfare Committee. It is planning institutes and clinical demonstrations in obstetrical procedures, has opened up instruction facilities in the Margaret Hague Maternal Memorial Hospital and other hospitals in the State; has set up, where needed, prenatal centers to be used as training centers for physicians; and has promoted regular conferences of the various maternal welfare groups in the county societies and medical organizations throughout the State. In addition, it is printing maternal welfare articles monthly in the State Medical Journal.

Lectures on *Child Health* are about to be given by a most capable staff of lecturers through the coöperation of the State Department of Health, the New Jersey Chapter of the American Academy of Pediatrics, and the Post-Graduate Committee of the State Society, Dr. Satchwell, Chairman, using Federal funds.

Some *Venereal Disease* literature is now being distributed by the Venereal Disease Con-

trol Committee and the Bureau of the State Department of Health, and we are hoping that both in *Venereal Disease* and *Tuberculosis* didactic and clinical post-graduate education will soon be available through the efforts of two able advisory committees on those two subjects.

In the other fields of Preventive Medicine, we hope gradually to develop available post-graduate education of different types, so that in the course of time any physician may find easily available specific assistance toward improving his ability to deliver better medical service in any of the phases of preventive medicine to his patients.

A most valuable form of assistance to interested physicians is that by which all of the present or future clinics or group service, such as the venereal disease clinics, baby keep-well stations, prenatal centers, tuberculosis diagnostic clinics, etc.,—are being utilized as training centers for physicians, and at the present time all physicians in New Jersey wishing to improve their knowledge of preventive medicine in these fields are urged to visit frequently any or all of these types of group work, and observe, and where possible, participate in the services therein offered. In this way, we are hoping that large numbers of our physicians will train themselves to improve their ability in these various types of Preventive Medical Services in their private practices.

THIRD STEP—DISTRIBUTION OF IMPROVED MEDICAL SERVICES

Step number three includes the delivery of improved services by:

a. The private practices of each member physician among his own patients, who will therefore act as a Family Health Adviser from the beginning of conception to the end of life. This large field, largely undeveloped, will gradually become a large and important part of the private practice of the future.

b. The development of practical plans by which County Medical Societies, after studying the community health needs in their own counties, will actually furnish the needed Preventive Medical Services by their physician members for the under-privileged groups who are economically unable to utilize the private practice of their physician members.

In most of the counties this is being done by the County Medical Societies furnishing qualified physicians for group services in the needed fields of Preventive Medicine, to health agencies both public and private, such as health departments, schools, nursing associations, parent-teacher associations, tuberculosis groups, etc., under specific, suitable agreements.

THE MIDDLESEX COUNTY PLAN

Particular attention of our State membership is directed to the effort of the Middlesex County Medical Society, who have, as noted in the February number of the State Medical Journal, page 139, organized its entire membership into committees in every possible field of Preventive Medicine, and are doing its utmost to furnish all of these Preventive Medical Services in the private practice of its member physicians.

There is no question that this is the best type of preventive medical care; and that the group method is an inferior method. This is clearly recognized in Dr. Vaughn's coöperative work between the Health Department of Detroit, Michigan, and the Wayne County Medical Society. In most of our counties, the set-up is such that this cannot be done at first; but we recommend that all of the other County Societies study closely the efforts of the Middlesex County Medical Society to demonstrate the feasibility of this method of delivering preventive medical services to all people in their county through the private practices of their members. The experience of this demonstration, as it develops in Middlesex County, will doubtless be of considerable assistance toward the development of similar types of delivery of preventive medical services in the other county societies.

We are particularly anxious that each of our members clearly understands that the better his practice of preventive medicine for his patients becomes, the less will be the inevitable residue which his county society must take care of in groups, in conjunction with the health authorities of the communities. Therefore, we hope that each fellow member will conscientiously provide, and urge upon his patients, this preventive medical care, and thus lessen the burden of his county medical society which has, or soon must necessarily assume the responsibility of providing preventive medical care for *all* residents of their respective counties. We hope it will be borne in mind that, in each of these preventive medical fields, organized medicine has but one choice in this matter if it is to protect the interests of its member physicians and preserve and maintain our control of preventive medical practice. This is by assuming full responsibility for every one of these fields, in conjunction with the official and non-official health agencies of the state and counties. In any case where this responsibility is not soon assumed by organized medicine, official or non-official health agencies will promptly assume it, to the detriment of the private practice of physicians; and much more

important, to the detriment of better medical service to the public.

THE FIELDS OF PREVENTIVE MEDICINE BEING DEVELOPED BY THE ADVISORY COMMITTEES

Most of the Advisory Committees are rendering reports of their work during the past year, which reports will be appended to this one. We would like to make brief comments on each of the various fields, including one or two fields that have had, so far, no committee appointed.

A. *The Field of Maternal Welfare.* The Committee on Maternal Welfare, under Dr. Bingham's able leadership, has developed the much more extensive program of assistance than probably any other state of the Union. Dr. Bingham's committee, and the county Committees have done tremendous amounts of work during this past year, to bring this program to the successful stage which it has now reached.

B-1. *Child Health Program.* Much of the Child Health program is carried on directly in connection with the Public Health Committee's efforts. Four of the Child Health Committee, Vice-chairmaned by Dr. Walter B. Stewart of Atlantic City, Dr. L. Charles Rosenberg, Dr. Ernest Hummel and Dr. Victor Blenkle have developed a splendid corps of State Society speakers on Child Health for the aid of the Public Relations Speakers' Bureau.

B-2. *Infant Health.* Dr. Murray and his committee, composed of Dr. Walter B. Stewart, Dr. Ernest G. Hummel, Dr. Benjamin M. Joseph, Dr. Irving Okin, and Dr. William London, all of the American Academy of Pediatrics, have put in a great deal of time and effort in developing, in conjunction with Dr. Satchwell's Post Graduate Education Committee of the State Society, an Infant Health Course, to be given in the Spring of 1937, at central points throughout the state. This course will be available to all physicians and paid for by Federal Funds.

To date, 67 physicians have been selected by the Public Health Committee of the County Medical Societies, and appointed by the State Department of Health for service in Baby Keep-Well Stations, to be guided by the denite standards and regulations adopted by the Welfare Committee on December 8, 1935. (Jour. Jan. 1936, p. 31.) The services of these Baby Keep-Well Stations are open only to mothers of the indigent and low-wage group. In many counties rotation of attending physicians has been approved, in order to train as many physicians as possible in the preventive aspects of infant health.

B-3. *Children of the Pre-school Age.* Following repeated conferences between the Public Health Committee; Mrs. Bowen, President of the State Parent-Teacher Association, and Mrs. Perry Hamilton, Chairman of the Summer Round-Up; the New Jersey Parent-Teacher Association has secured the approval of the National Parent-Teacher Association for the use, this spring, of the pre-school blank of The Medical Society of New Jersey, as the only official blank for this year's summer round-up. (Jour. Sep. 1934, p. 546.) This is a forward attitude on the part of the New Jersey Parent-Teacher Association, who have agreed also to recommend, for a three weeks' period previous to the Summer Round-Up, itself, that all parents take their children who are about to attend school to their own family physician and have the child examined, using our State Society Pre-School Blank. Last year, over 700 of the 5,000 children examined during the Parent-Teacher Association Summer Round-Up were done by their own family physician. We are hoping this year that there will be a great increase in this number by using these blanks, and also that the family physician will thus assume health supervision over many pre-school children from age two to six, and thus develop continuous child health supervision by the family physician,—a very desirable step.

We are hopeful that all of our physician members and the officers of our County Medical Societies will appreciate this forward-looking and coöperative attitude on the part of the officers of the New Jersey Parent-Teacher Association; and will heartily cooperate in this effort to improve the health of the pre-school child, and make that group of children more healthy and more fit to enter school life. This is an opportunity for the medical profession to assume the health supervision of pre-school children of this state, if each physician and each county society public health committee does its part in the Spring Round-Up (and the Fall Check-Up) during this effort.

B-4. *Children of School Age.* Dr. Allen G. Ireland, Director of Health, Safety and Physical Education of the Department of Public Instruction of the State of New Jersey, is developing a series of blanks, by the use of which our committee expects to integrate the family physician more closely into the health supervision of the child of school age. Plans are being devised by which the school authorities will urge each family to have these blanks filled out annually by their family physician, together with specific recommendations from the family physician to the school authorities

concerning various phases of the health of the child under his private supervision.

By these three methods we are gradually devising a practical system whereby the family physician will carry on continuous health supervision through infancy, the pre-school age, and the school age.

A special committee is now working on a continuous child health record which will cover the essential record of child life from conception through birth, infancy, pre-school life, school life, the secondary school and even the college period. Such a health record will be invaluable, both as a record containing the essential facts necessary for the proper supervision of these various periods of growth, but also of educational value for the public. It will show the proper position of the family physician as a *health advisor* through the *entire growth period.* This record will be a compilation and condensation of the records now used by Dr. Bingham's committee, Dr. Levy's division, the State Medical Society's Pre-school Blank, Dr. Ireland's school record forms, and Dr. Kler's Rutgers University forms; and will eventually be one of our most forward steps in our developing program of health supervision since it covers the *entire period of child life and growth.*

C. *Cancer Control.* The Cancer Control Committee, under Dr. Orton's Chairmanship has made an extensive study of the facilities available for control and treatment of cancer throughout the state. The report has been printed in the Journal of February, 1936, p. 114, and will be followed by concrete plans along many lines for medical leadership and participation in the development of cancer control.

This subject of cancer is most important, and will doubtless continue to receive an increasing share of public and other funds.

D. *Tuberculosis Control.* Dr. Pollak's committee is actively promoting further development of the approved plan of last year whereby the teen age will be Mantoux tested, the positives x-rayed for the early detection of tuberculosis. The development in many counties, such as Union, where the Medical Profession, the Tuberculosis and Health Leagues, Health Departments, and the Educational Authorities are joining hands for the early detection of tuberculosis, is an integral step in the control of this disease.

The Federal Funds for control of the *Negro Tuberculosis Project* of the State Department of Health are available, but further progress must be made in developing personnel to get this project actively under way. As each county society develops the work of its physicians who are especially interested in tuberculosis, these tuberculosis medical groups will be of great assistance in each county in promoting the preventive aspects of tuberculosis control.

E. *Venereal Disease Control.* Dr. Shivers and his most able committee have been busy building the groundwork of this venereal disease program, which is rapidly developing under Federal funds. The committee is working actively with the venereal disease bureau of the State Department of Health, in setting up assistance to physicians, and means whereby the venereal disease cases can be located and treated. County Medical Society Committees are being appointed, and plans are being laid whereby County Medical Societies will recommend qualified physicians in this field to meet the needs of the New Jersey program.

Early in the year, Dr. Parran, Surgeon General of the United States Public Health Service, had made the statement that "In many rural communities, for obvious reasons, many cases would not accept the group methods; and that in such places, States might do well to subsidize qualified physicians in rural areas, and pay them for their services, to be rendered in their own offices". Following this statement, we introduced a resolution which was passed by the State Board of Health, requesting that a part of the funds be utilized to pay physicians in rural districts, for doing this work in their own offices. We hope the Venereal Disease Control Committee will be able to help in the education and qualifications of interested member physicians to do this work, and will succeed in having much of it done in the physicians' offices, outside of cities where hospital and other clinics already exist. A nation-wide campaign is under way, and it is very important that our State Medical Society take a prominent part in the active leadership of this movement.

F. *Crippled Children.* Dr. Weigel's Committee has worked closely with the State Crippled Children's Commission, in seeing that qualified physicians carried on this program and that hospitals had proper equipment for doing this work. The members of Dr. Weigel's Committee have studied the economic state of the crippled children's movement, and are taking this up with Dr. Lewis's committee, in order that crippled children will receive good care, and at the same time, the practice of physicians will be protected.

G. *Mental Hygiene.* Dr. Plant and his expert committee have made some initial outlines of this most important field, and its importance can easily be recognized by the fact that there are more hospital beds in New Jer-

sey for mental disease than for all other forms of illness. The searching out of the causes of mental disease, the prevention of mental conditions which lead to more or less permanent hospitalizations, and the arrest of the steady increase of mental hospital admissions in New Jersey, is a Public Health work of the first magnitude. The field is vast, and parts of it unknown. We have tentatively planned a method of attack, beginning with habit-training in children, child-guidance facilities, parent-child relationship, help for the mental problems of the adolescent, (such as sexual education, vocational guidance, home adjustments) and for the adults, a study of their mental problems, etc., etc., in conjuntion with State Mental Hospitals and mental disease experts. This development is necessary, because the public health expense of supporting mental cases in this state runs into millions of dollars annually; and the diminishing of this expense would be well worth a great deal of money on the part of public agencies.

Because of the pressing needs of developing our other urgent public health fields, we must perforce make progress slowly in this field until we are better embarked and on our way in some of the other fields, but we will continue to lay plans for the mental hygiene field.

H. *Public Health Hour.* The public health hour which served its useful purpose of focussing the attention of health workers and the public on the actual responsibility of the private physician in regard to public health, has become an integral part of public health work. We have carried on no particular campaign this year; and already, on March 1st, at the time this report is written, the toxoid administrations and the vaccinations have reached a total of over 20,000, and 13,000 respectively, with four months more of the public health hour to come. Thus we will far exceed the records, which have increased yearly, without any special campaign.

The experience of the previous two years has been such that the Health Officers' Association has requested a continuance of the public health hour with some change in the regulations,—which change has been approved by the Committee and the Welfare Committee and will shortly be put into effect by the State Department of Health. They have been printed in detail in the State Journal, of December, 1936, p. 721, but the essential points are:

1. The cases will be taken care of in the doctors' offices at one dollar per treatment.

2. The Health Department will make every effort to get all cases done by their own physicians during the first few years of life.

3. The indigents shall be done by the public authorities.

4. The residual group (after every effort has been made for a long period of time to get these cases done by their own family physician) will be done by the public authorities.

5. Free toxoid and free vaccination material shall be furnished every physician in New Jersey for all classes of cases, (private, public health hour and all), the only requirements being that the physician report the cases to the Department of Health as having been immunized or vaccinated on a certain date. This is in line with the policy in many large cities and several states, that there shall be available to the Medical Profession free biologicals for the control of all contagious diseases.

APPOINTMENTS OF PHYSICIANS FOR PUBLIC HEALTH ACTIVITIES

Through the constructive coöperation of the State Department of Health, we have been able to have qualified physicians for public health needs under the Social Security Act recommended and selected by the County Medical Society, in the Maternal Health, Child Health, and the Venereal Disease Control programs. It is extremely important that this policy of appointment be adhered to, if the quality of public health service by State and county medical societies is to continue, and be an essential item in developing the teamwork of our medical societies and health departments.

Our assumption that anything that has to do with the health of the public can best be set up by the State and County Medical Societies and state and local Health Departments working together, with the aid of other health professionals, and lay health groups, has now been amply justified by our forward progress to date in the Social Securities Health Program. This type of plan, and our public health hour have now been copied in most of the states of the Union, which is ample proof of the inherent soundness of our approach. Our definite object is to integrate as many of our member physicians, in as many ways as possible, into all of the health programs of every sort, in New Jersey. By so doing, we will gradually make progress toward making *every physician's office in New Jersey a health center for the practice of preventive medicine*, and develop that assumption of health leadership by the profession as a whole, which will lead to *Better Medical Service* for each person in New Jersey.

RECOMMENDATIONS

Recommendation No. 1. That the Medical Society of New Jersey send a resolution of thanks and appreciation to the State Depart-

ment of Health of New Jersey for its consideration of the Medical Profession of New Jersey, and its coöperation in the utilization of the Federal Funds of the Social Security Act, in conjunction with the various Health Committees of the Medical Society of New Jersey toward the constructive joint development, during the past year, of *Better Public Health* for the citizens of New Jersey.

Recommendation No. 2. That, in order to develop close teamwork between the County Medical Society Health Committees and the State Health Committees, that the County Societies be urged by the President of the State Society to construct their County Society Public Health Committee for the coming year, for better efficiency, by selecting as a minimum the following type of committeemen:

First—as Chairman of the Public Health Committee—the physician member of the County Society most interested in the whole Public Health program and best qualified to develop that program.

Second—the member physician most interested in the Maternal Welfare program.

Third—the member physician most interested in the Child Health program.

Fourth—the member physician most interested in Adult Health Supervision.

Fifth—the member physician most interested in Cancer Control.

Sixth—the member physician most interested in Tuberculosis Control.

Seventh—the member physician most interested in Venereal Disease Control.

Eighth—the member physician most interested in Mental Hygiene.

Ninth—the member physician most interested in Crippled Children.

It is recommended that, in large county societies, such physicians be chairmen of subcommittees in any or all of these various fields. In this way, the Public Health Committee will be sure to contain a nucleus of our physicians keenly interested and especially qualified in these various fields.

In some counties, this has already been done, as suggested,—but in order to develop our assumption of health leadership in all of the counties, it is very important that as many of the other counties thus increase the efficiency of their public health personnel. By so doing, the State Advisory Committee will, in each case, have a physician or committee to work with and through, in each county society, and our public health program will be correspondingly improved.

Recommendation No. 3. That each County Medical Society appropriate sufficient working funds for its Public Health Committee to operate efficiently on behalf of its physician members.

Recommendation No. 4. That the State and County Societies shall continue, by all possible means to aid their physician members, (by means of post graduate education, literature, clinical demonstrations, training centers, etc.) to improve their personal delivery of preventive medical services to their own patients, and their ability to act as continuous health advisers, during the various age periods, from birth to the end of life.

Recommendation No. 5. That the officers of each County Medical Society and its Public Health Committee make a joint study of their own county needs in each of the preventive and public health fields, and develop definite plans, in conjunction with the State Society's existing health programs, and with the coöperation of the local health departments and lay health agencies, to do their utmost to make progress toward providing for those needs (which will vary considerably in different counties) for all of the people, by the carefully planned utilization of the services of their member physicians. Such studies and plans, followed by progressive action, will go a long way toward focussing public attention on the fact that the County Medical Society has assumed leadership in providing for the Public Health needs of each county, in conjunction with the health departments and lay health agencies, and undertakes its proper share of responsibility to develop better medical services for the people in each community.

It is now essential to make clear the fact, already pointed out two yeras ago by the American Medical Association, that in the same way that a physician is responsible for the best possible medical service to his patient, the County Medical Society (and State, and A. M. A.) is assuming responsibility for better medical service, both preventive and curative for the entire public.

By this method only can the essentials of private practice be preserved and Better Medical Service rendered the citizens of this state, through making *every physician's office in New Jersey a health center for the practice of preventive medicine.*

Respectfully submitted,

Stanley Nichols,
Chairman

A. E. Jaffin,
Theodore Teimer,
Julius P. Levy,
I. W. Knight,
Ernest G. Hummel,
Allen G. Ireland.

REPORT OF THE SUB-COMMITTEE ON MEDICAL PRACTICE

By Thomas K. Lewis, M.D., Camden, N. J.

To the Welfare Committee:

The Sub-Committee on Medical Practice has had no major project during the past year. With the creation of the six advisory committees, most of the recommendations presented by the mother committee during the past few years are being studied and worked out in greater detail. The majority of the members of the Sub-Committee on Medical Practice have been involved in the activities of the various Advisory Committees.

The chief concern of the Medical Practice Committee is that of the economic picture of the practice of medicine as a whole. As the work and reports of the advisory committees develop, it will become apparent that there is much overlapping and close interrelationship. Proper coördination of the various activities and recommendations of these several committees rests with the mother committee. Since the reports of the advisory committees are only recently completed, it is obviously impossible to present at this time a summary of the year's activities. Therefore, the final word will be presented in the form of a supplementary report at the Annual Meeting.

Respectfully submitted,

Thomas K. Lewis, *Chairman*
J. Irving Fort
Chester I. Ulmer
D. Leo Haggerty
Louis A. Pyle

REPORT OF THE SUB-COMMITTEE ON LEGISLATION

By B. S. Pollak, M.D., Jersey City, N. J.

To the Welfare Committee:

The activities of the Sub-Committee on Legislation are largely seasonal, and consist principally of the study of bills introduced, the analysis of important bills having health implications and the contacts of the Executive Officer, Dr. Wilkes, and the county medical society key men with the legislators during the sessions of the State Legislature. So far this year the work of the committee has been relatively light, for it was not deemed advisable to introduce new legislation of our own, and the bills of sufficient influence on medical practice to enlist our active support or opposition have been few and have been held in committee up to the time of making this report. The Legislature is still in session, and in our supplemental report, if one is necessary, we will bring out any new developments which take place before our Annual Meeting in Atlantic City in April.

Three legislative bulletins were issued, and these have been duly recorded in The Journal.

Three cult bills (A-233, A-235, and A-236), introduced by Assemblyman Muir of Union County, have not come out of committee; nor has A-34, which aimed to add a plumber on the State Board of Health.

A-359, a paternity blood-group test bill, was sponsored by the Welfare Committee.

Several bills affecting the Workmen's Compensation Act were approved by our Workmen's Compensation Committee.

The members of the committee have done everything asked of them, and have the thanks of the Chairman.

Respectfully submitted,

B. S. Pollak, *Chairman*
Samuel Alexander
William H. Areson
William Costello
Charles H. Mitchell

REPORT OF THE SUB-COMMITTEE ON PUBLIC RELATIONS

By Joseph H. Kler, M.D., New Brunswick, N. J.

To the Welfare Committee:

It has long been evident that the medical profession has neglected its civic responsibility. In its admirable and ideal organization it has devoted its energies to scientific advancement for the welfare of the people. The profession may justly be proud of its record.

SOCIAL REORGANIZATION

Unfortunately, during this time we have had an unusual social reorganization. Its causes are of relatively little importance to us, but its implications are of the greatest importance. We are now dealing with a society of *groups* instead of a society of *individuals*. Further, people of today are extremely interested in everything affecting them. Their intellectual curiosity must be satisfied for their happiness. Through our neglect in recognizing these needs various quackeries and quasi-medical organizations have assumed the responsibility of informing the public on all health matters. Through their conniving, the profession has been set even farther apart as a purely scientific organization not interested in its social opportunities and responsibilities. Sociologists have recognized the appeal of health in their manipulation of social orders. Instead of assisting economists to insure an adequate income for everyone, they have advocated unlimited medical care as a panacea for the social and economic ills of this country. The more radical "social changers" have advocated some form of socialized medicine, and have many followers because people in general do not understand the problems of medicine. Apparently there is no immediate danger; but the danger is there just the same.

REACHING THE PUBLIC

The medical profession still has the respect and confidence of the public. However, we need to bridge the gap between the profession and the public. Utility companies, insurance companies, banks, and other kinds of private business realize the need of securing the public's good will, and they organize public relations bureaus to accomplish that purpose. Medicine, which has a greater service to offer than any of these, needs to have its aims and its facilities even more thoroughly understood by the great mass of people. We of the profession know that medical men are much more philanthropic in intent and in fact than they are given credit for being. The necessarily high cost of medical and surgical treatment must be satisfactorily explained; the greater economy of preventive, rather than curative medicine, must be established in the public mind; and the medical profession must doff the cloak of terminology behind which the layman feels he can not comprehensively penetrate.

Intelligent publicity work could do much to accomplish these ends, but it must be in a restrained key in order not to assume the aspect of unethical salesmanship. If we do our part well, the public will demand a continuation of the present organization of medicine for its own safety. That should be our goal.

The Sub-Committee on Public Relations has accepted its opportunity. We have developed an ideal program that will always permit flexibility of action. Its aims are:

1. Secure the active good will of the public.
2. Educate the public to appreciate the problems of its health care, so that it will demand a continuation of the present organization medicine (American).
3. Supplant the "patent medicine trade" in the health education of the public.

PROGRAM OF ACTIVITIES

The following is the plan of our activity:

1. Speakers' Bureau.
   a. State Speakers' Bureau.
   b. County Speakers' Bureau.

Both are organized in a similar manner, in order to have a speaker on every phase of health care. The State Bureau will be available for state-wide audiences. The speakers will furnish a short synopsis of their talk, to permit better publicity and to aid the Auxiliary in its work.

The activity of all County Speakers' Bureaus on problems of health in general. Addresses to P.-T. A. groups are on the various problems of child health. Addresses to Service Clubs and other fraternal organizations are on problems of health in general. Addresses to Women's Clubs are on health problems peculiar to women.

There are no talks specifically on Medical Economics unless requested. However, there is an indirect but definite reference to this subject in every address by emphasizing the fact that all accomplishments in the reduction of mortality have been due to the unhampered activity of the profession. Each address points

out, in a few words, the unselfish philosophy of the profession.

2. The Package Library on any health problem.

a. There is a collection of material on all recommended topics for addresses. This material is available to all speakers in the preperation of their addresses. Prepared addresses are also available for speakers who do not have time to prepare their address.

b. Information on medical economics is available to responsible lay organizations.

c. The A. M. A. will supplement material by loans.

3. Newspaper Publicity.

a. "Health" articles, similar to those of New York Academy of Medicine releases, will be sent to all newspapers.

b. Articles will be published in Health Progress, the official publication of the New Jersey Health and Sanitary Association.

c. Articles are prepared for the Bulletins of the P.-T. A., Federation of Women's Clubs and Association of University Women.

4. Improve relationship with the press.

a. Supply information on health to all editors in form of editorials. Also in communities that have acute health situations, supply authoritative information to permit the editor to write intelligently and authoritatively.

b. At the annual meeting of the Society, provide a press room and assist reporters. When expedient, write news releases ahead of time.

5. Radio broadcasts similar to those of the A. M. A.

a. First series to consist of eight weekly broadcasts. Addresses to be on Health in New Jersey, Heredity, Prenatal Care, Nutritional Problems of Infancy and Childhood, Health Problems of Childhood, Tuberculosis, Heart Disease, and Cancer. The various women's clubs will conduct study groups at the time of the broadcasts with the address as the study topic.

6. Request each County Medical Society to appoint a committee to advise libraries on health books and magazines.

7. Contact lay organizations for their cooperation.

a. Such contacts with the following women's organizations have been made and active coöperation has been secured: New Jersey Federation of Women's Clubs, New Jersey Congress of Parents and Teachers, American Association of University Women (New Jersey), New Jersey Association of Public Health Nursing, New Jersey League of Women Voters, New Jersey Business and Professional Women's Clubs. The membership of these organizations represents the intelligent and active leaders of our communities. They will carry our messages to every home.

b. Similar contacts with various professional groups have also been made.

8. Contact all State and Federal Legislators, and inform them that we shall send them from time to time information on health from various sources in the hope that it may assist them in solving problems of general welfare of the people of New Jersey.

Then send them selected articles by physicians and others that have a favorable bearing on the philosophy and ideals of organized medicine, such as speeches by the President of the A. M. A., etc.

9. State-wide Health Day, to be sponsored by each County Medical Society in coöperation with all voluntary health agencies, official agencies, and pharmacists, possibly in connection with May Day. Have the Governor issue an appropriate proclamation.

10. Take an active part in all State-wide programs concerned with the general health of the people.

a. As a result of the Conference on Venereal Disease Control arranged by Surgeon General Parran, the American Social Hygiene Association sponsored a Social Hygiene Day on February 3rd. The New Jersey Health Department organized a campaign to make the people of New Jersey aware of the venereal disease problem in our State. To complete this program, the technical knowledge of the profession was necessary and your Public Relations Committee joined this campaign to bring The Medical Society of New Jersey into the picture. Every agency expressing its willingness to hold meetings on venereal disease control was contacted. Through the wholehearted coöperation of the Public Relations Committees of the various counties and the State Committee on Venereal Disease Control, speakers for some fifty meetings were supplied. These meetings have been conducted throughout the months of February and March. On February 3rd alone, Drs. A. Haines Lippincott, C. Byron Blaisdell, and Charles H. deT. Shivers addressed audiences totaling 450 people. All audiences addressed on venereal disease control can be conservatively estimated at 40,000.

b. A similar program on Maternal Health has been arranged with the New Jersey Federation of Women's Clubs. Dr. Arthur Bingham has organized speakers in each county to facilitate matters. This program has been made possible through the coöperation of Mrs. Alfred Driscoll and Dr. Mabel Haines, President

and Welfare Chairman, respectively, of the N. J. Federation of Women's Clubs.

c. On March 6th the National Public Housing Conference sponsored a meeting in Princeton on Slum Clearance. Because this Conference had definite health implications, your committee took an active part in the meeting.

d. Your committee also played a very active part during the recent passage of the Pure Food and Drugs Legislation. A special committee made a careful analysis of all proposed legislation and prepared an amendment to the Wiley Law. After the Welfare Committee approved the report, the Public Relations Committee arranged with Senator A. Harry Moore the preparation and introduction into the Federal Legislature an amendment to the Wiley Law known as the Moore-Towey Amendment. Effective publicity was secured throughout the United States and the active coöperation of the national officers of the various women's clubs was secured. All this was accomplished in five days. We wish to express our appreciation to Senator A. Harry Moore and Congressman Frank W. Towey for their splendid coöperation. We have every reason to believe that our activity stimulated the amendment of the Copeland Bill which passed in the Senate in a very amended form. Congressman Towey is actively working for the strengthening of the weak points of the Copeland Bill. We have maintained the active interest of the various national organizations in this legislations and have every reason to believe that the final bill will give us effective legislation.

e. Your committee is also actively coöperating with the State May Day Committee in the preparation and presentation of its program.

The organization of this program will be completed within the next two or three months.

Then there will be the task of supplying information to this large mailing list at necessary intervals. It will mean a mailing list of at least 10,000. It is obvious that certain physical equipment and trained personnel will be necessary. No member of the committee has the time or training necessary for this work.

RECOMMENDATIONS

It is recommended that the House of Delegates establish a *Public Relations Bureau* to carry on the program that has been initiated. Such a Bureau can be established at a modest expenditure by integrating it into the present Executive Office Staff. This will eliminate duplication of office equipment.

A trained young journalist is essential. He can put into understandable terms the ideas of the profession as expressed through the Sub-Committee on Public Relations. A journalist speaks the language of the press. It is a language that medical men do not speak. Virtually our recommendation is merely an adequate budget that will permit the maintennace of a large mailing list, and the hiring of a trained journalist to carry out the detail work of the Sub-Committee on Public Relations.

The following budget has been submitted to the Finance and Budget Committee:

Salary of a properly trained young journalist	$2000.00
Stationery, etc.	375.00
Stamps	375.00
Reprints, etc.	500.00
Incidental expense	750.00
Contingent fund for first year	100.00
Total	$5000.00

Your committee believes that the program initiated is not only worth while, but is essential for the integrity of the profession. All activities should be carried on during the coming administration.

The work of the Speakers' Bureaus should be encouraged, for it is through that medium that we shall make our best contacts.

The radio offers another excellent medium, especially when correlated with study groups of women's clubs.

The press should also be cultivated. Making contacts is a simple matter. The great difficulty is to supply good publicity regularly.

Respectfully submitted,

Joseph H. Kler, *Chairman*
Hilton S. Read
S. Emlen Stokes
E. P. Cardwell
Wright MacMillan

REPORT OF THE ADVISORY COMMITTEE ON CHILD HEALTH

By Walter B. Stewart, M.D., Atlantic City, N. J.

To the House of Delegates:

This year's activity of the Child Health Sub-Committee has been the supplying of capable speakers on child health subjects to the Public Relations Committee, which furnishes speakers on medical subjects, upon request, to community agencies.

The Committee has selected from the pediatricians and those physicians of New Jersey interested in child health work about 40 physicians who are well equipped to present the subject of child health before lay organizations throughout the State. These names and the phases of the subject with which the doctors are best acquainted have been submitted to Dr. J. H. Kler, Chairman of the Public Relations Committee, thus enabling him to fill present and future requests for this type of coöperative service.

Respectfully submitted,

Walter B. Stewart,
Vice-Chairman.
Ernest G. Hummel
L. Charles Rosenberg
Victor A. Blenkle.

REPORT OF THE ADVISORY COMMITTEE ON MATERNAL WELFARE

By Arthur W. Bingham, M.D., East Orange, N. J.

To the Welfare Committee:

During the year the committee has been busy carrying out the program of twelve points which have been published in the Journal of December, 1936, page 716, and are as follows:

1. Adequate provision for prenatal care: (a) By physicians in their offices; (b) in prenatal centers to be established where needed.
2. More hospitals with isolated maternity departments.
3. More open hospitals where general practitioners may bring their patients subject to supervision and with rules for consultation in abnormal conditions.
4. Regular conferences of maternal welfare groups with all physicians interested in obstetrics.
5. Investigation of every maternal death in each district, not for criticism, but in search of knowledge to prevent another.
6. A field physician for every district.
7. Free nursing delivery service for the low-wage group.
8. Free consultation for the low-wage group.
9. Free consultation for midwives in the low-wage group.
10. Lecture courses. Distribution of literature to improve maternity care.
11. Short refresher courses in obstetrics and maternal welfare.
12. A maternal welfare article printed each month in the Journal of The Medical Society of New Jersey.

MEETINGS

There have been seven meetings held with the Field Physicians, and two with the members of the Maternal Welfare Committees of the various counties as well as the Field Physicians. The Chairman has had one meeting with the State Board of Health in Trenton, and almost weekly conferences with Dr. Levy, its representative.

The meeting of the Advisory Committee in Newark on January 21st was attended by representatives of every county in the State, and was the best meeting we have ever had. Dr. Snedecor and Dr. Wilkes were present and took part in the discussion which continued from 4 until 7 p. m., when we adjourned for dinner. Each point in the maternal welfare program was discussed, and many questions were answered.

After dinner, we attended a lecture given by Dr. Walter T. Dannreuther, of New York, on "Supra-vaginal Hysterectomy" at the Academy of Medicine of Northern New Jersey.

RESULTS

For eleven months, up to March first, there were 423 maternity cases in the low-wage group on which physicians used nurses who were paid by the State Board of Health. There were fifty-nine consultants on similar cases

called by the attending physician, and paid in the same way. Each case in both groups was checked by the chairman of this committee. These services are of great value in the prevention of complications, and should aid materially in the improvement of obstetrics throughout the State. Physicians in some counties have used these services very little, and we feel that it is due to a misunderstanding of some of the details.

Although in operation only a few weeks, six physicians have taken advantage of the refresher course given by Dr. Samuel A. Cosgrove and his associates at the Margaret Hague Maternity Hospital. They report having found the course very interesting and instructive.

Charts showing an analysis of maternal deaths in each district have been sent to each field physician to aid him in his work. Maps were made showing how each county stood in the six principal classifications of maternal deaths.

FUTURE PLANS

The plans for the coming year include carrying out the same program more intensively with one or two changes. In place of lectures a series of conferences will be given with small groups all over the State. These will be held largely in hospitals and will consist of demonstrations and discussions with obstetricians of experience as leaders.

An effort will be made to obtain a report each year on the obstetrical work being done in every hospital in the State.

The committee is glad to be able to report a new low maternal mortality rate for 1936,—3.7 per thousand live births. This compares with 4.5 for 1935, and 5.9 for 1931 when the committee was first appointed.

There were 202 maternal deaths, six of which occurred outside of the State;—fifty were due to abortions and ectopics, twelve were due to medical causes not related to pregnancy, and 134 were true obstetric deaths, or 2.4 per 1,000 live births.

Respectfully submitted,

Arthur W. Bingham,
Chairman
Walter B. Mount
H. B. Wilson
Carl H. Ill
Samuel A. Cosgrove
P. DuBois Bunting
J. Carlisle Brown
F. D. Fahrenbruch
Theodore F. Thompson
Robert A. MacKenzie

REPORT OF THE ADVISORY COMMITTEE ON CRIPPLED CHILDREN

By Elmer P. Weigel, M.D., Plainfield, N. J.

To the Welfare Committee:

The chief aim and activity of our committee has been to correlate the work of the Crippled Children in this State, which under the Social Security Legislation is vested directly in the Governor's Crippled Children's Commission. The Crippled Children's Commission receives whatever monies are available from the Federal Government to be used to carry out the program in New Jersey, and our committee feels that our chief function is to advise the Commission in all matters pertaining to the medical care of these unfortunate children. Therefore, with this idea in mind, we have met with the Crippled Children's Commission on several occasions and your Chairman has been in constant touch with Mr. Joseph G. Buch, the Chairman of the Crippled Children's Commission, and, after discussing in detail all the various phases of this portion of the Social Security Act, it was decided by the committee, and agreed to by the Commission:

1. That no hospital should be approved for crippled children's work unless it has met the minimum requirements of the American College of Surgeons.
2. That the committee would sanction care of crippled children in New Jersey by recognized orthopedic specialists from adjoining states who were members of the American College of Surgeons or the American Academy of Orthopedic Surgeons, but felt that an effort should be made to bring these patients under the care of New Jersey surgeons.
3. That in order to stabilize the work and properly protect our crippled children, their care should be restricted to those who are best qualified in that area to do this work.
4. That the nurses who are to be intrusted with the after-care of these crippled children must in each instance be acceptable to the doctor who is to be interested in the medical care of the patient.
5. That the committee is in accord with

the action taken by the Crippled Children's Commission in establishing facilities at Vineland, New Jersey, for the study of cerebral birth palsy. Realizing his qualification for this work, the committee was also of the opinion that Dr. Winthrop M. Phelps be placed in charge of this work.

It is our firm belief that we have established with the Crippled Children's Commission, through its chairman, a very workable arrangement whereby each crippled child in the State will receive adequate treatment from the best orthopedist in each locality, and that there will be funds available for all necessary apparatus.

The committee has requested the Crippled Children's Commission to ask each operating surgeon to render a bill to the Commission for each case treated so that a value may be placed upon the work done by members of the profession, and insofar as the Federal money becomes available an effort will be made to compensate the doctor for his care of these cases.

At the present time it is impossible to state to just what extent this will be possible, but it is the hope of both your committee and the Crippled Children's Commission that, if the present Social Security arrangement remains in force there will soon be actual funds available for the payment of professional care of these children.

It is the recommendation of our committee that the present cordial relations between it and the Commission remain in force so long as the Social Security Program for the care of Crippled Children remains active.

Approved.

Respectfully submitted,

Elmer Peter Weigel,
Chairman
F. G. Dilger
Thomas K. Lewis
Frank H. Pinckney
Barclay W. Moffat
David B. Allman

REPORT OF THE ADVISORY COMMITTEE ON TUBERCULOSIS

By B. S. Pollak, M.D., P.A.C.P., Jersey City, N. J.

To the House of Delegates:

In order to make an impression upon society relative to the efficacy of Tuberculin Testing, its significance and importance, organized medicine in itself must, by precept and example, demonstrate its unqualified support thereof. Thus it becomes obvious that the passage and acceptance of the resolution, relative to this problem, by the Committee on Public Health of our State Society and its Welfare Committee, are not sufficient.

A militant organization, within our State Medical Society, must be ready to demonstrate to the citizens of our State, our loyal support and our belief in such a measure. In this way we shall have the opportunity once again to bring to the fore our altruistic attitude in relation to the advancement of public health.

A year has almost passed since the promulgation of the resolution, previously referred to, and we find but sporadic evidence in interest and coöperation.

In order to effectively initiate this movement, concerted effort will be required—casual attempts will not avail. Thus, occasional examinations of individuals, or even small groups, are not sufficient.

We believe only by mass effort will our attitude be justified and its fruitful benefits to our people emphasized. We, therefore, appeal for a renewal of interest—for putting into operation in every county in our State, Tuberculin Testing and Follow-up by X-ray of the teen age groups of the high school students.

Your committee, therefore, suggests that through the medium of our Committee on Public Health of the State Society and the respective County Medical Societies, educational propaganda be disseminated; to this end the members of our committee offer their services, which, of course, will have to be augmented by the members of the profession connected with the various tuberculosis organizations throughout the State.

The larger cities and counties in our State have the opportunity to offer to the medical profession facilities for the study and scientific application of this test. In the smaller cities and counties similar efforts should be initiated. We suggest that the hospitals of this State should open their doors to the tuberculous patients. This will provide facilities to the profession at large to familiarize itself with the essentials in connection with tuberculin testing. We believe that in this way opportunities will likewise be afforded for the application of pneumothorax treatment—a treatment which is so rapidly making inroads in the newer concepts of the control of tuberculosis.

We believe that through the medium of the

Department of Institutions and Agencies further facilities will be made available.

In order to emphasize the fact that other communities throughout the Union are actively interested in this matter, we beg to advise that the City of Detroit, commencing January 1, 1937, initiated a five-year program for which one million dollars has been budgeted and in which the medical profession of Detroit will be permitted to participate.

We, in New Jersey, have no city the size of Detroit, and hence a sum of so large a proportion will not be required, but in the larger counties, notably Essex, Hudson, Bergen, Passaic, Camden and Union, efforts should be made by the profession to forthwith proceed. Let us not wait until non-medical organizations be forced into leadership.

We believe that if an earnest effort be made by us to impress governing bodies, to wit: Councils or Commissions of the various cities or the Boards of Chosen Freeholders in the respective counties in the State, that our efforts in the direction indicated will prove to be an economic investment, but more important than the financial gain will be the protection afforded to the children of our State against the development of disease.

We further believe that through our channels, legislation relative to the matter of tuberculosis control should be reintroduced, patterned along lines of former efforts. These bills should be introduced by us and for this purpose we are submitting for the approval of the Committee on Public Health, as well as the Welfare Committee, copies of bills introduced in 1936.

All of which is most respectfully submitted by the Committee on Tuberculosis.

Respectfully submitted,

B. S. Pollak, *Chairman.*
J. R. Morrow
Samuel B. English
Frederic W. Lathrop
J. F. Pessel
George M. Levitas

REPORT OF THE ADVISORY COMMITTEE ON CANCER

By Henry B. Orton, M.D., Newark, N. J.

To the House of Delegates:

The objectives of the Cancer Committee this year were as follows:

To organize cancer clinics—diagnostic, therapeutic, or both—in hospitals of various counties.

To encourage discussions on cancer at the county society meetings at least once a year.

To organize cancer committees in the several county societies; and to encourage the development of hospitals for indigent cancer patients.

COUNTY ORGANIZATIONS

The following counties have organized cancer committees at the present time: Middlesex, Warren, Somerset, Bergen, Passaic, Essex, Hudson, and Union. Also two-third of the counties have had a special program dealing with the subject of cancer.

We are presenting six charts which illustrate several phases of the cancer problem.

Charts 1 and 2 show the rapid rise of cancer as a cause of death in New Jersey. In 1905 there were 57.7 deaths from cancer in each 100,000 of population; while in 1930 there were 123.8.

Chart 3 shows the number of New Jersey residents dying from cancer in each 100,000 of population.

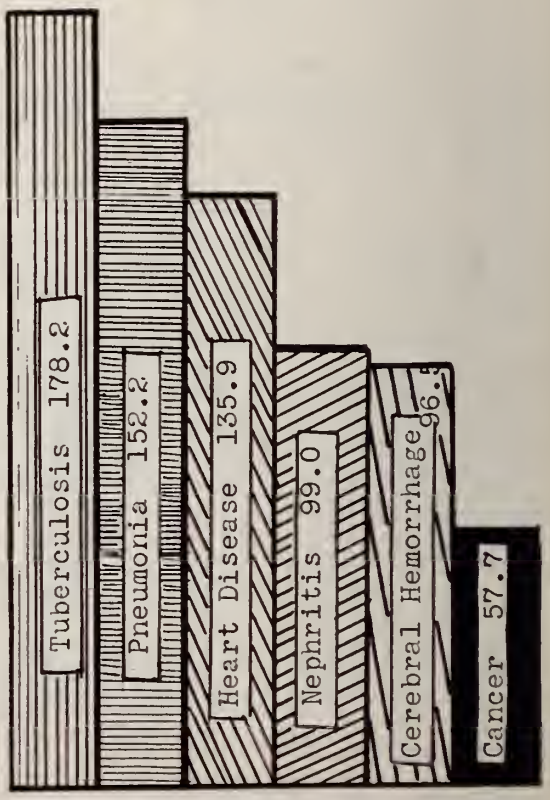


Chart 1.—Deaths from principal causes in New Jersey per 100,000 population in 1905.

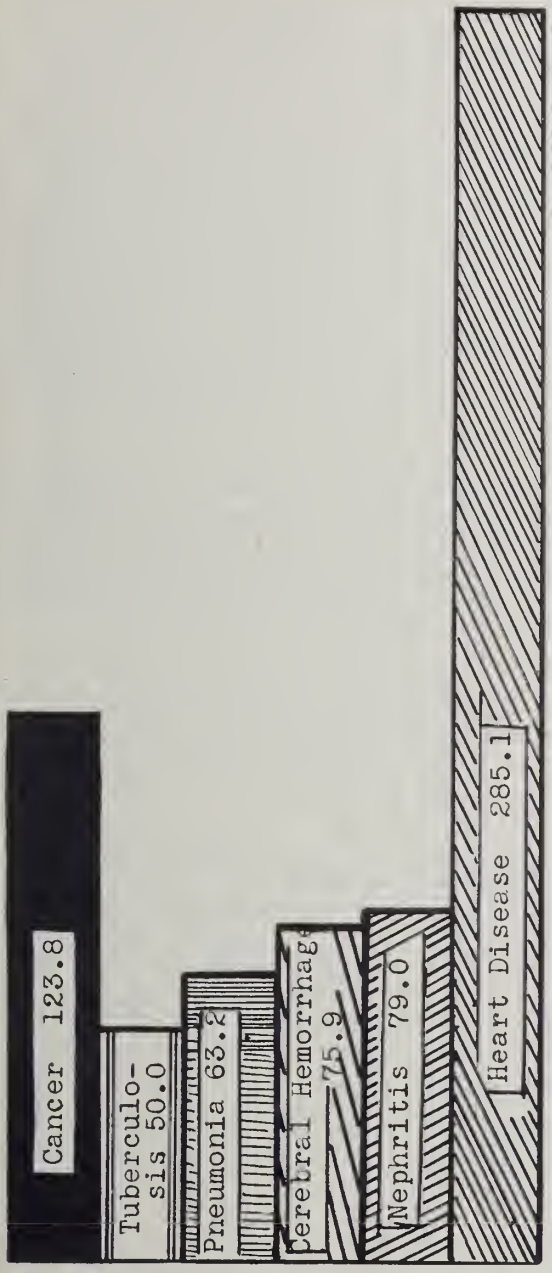


Chart 2.—Deaths from principal causes in New Jersey per 100,000 population in 1935.

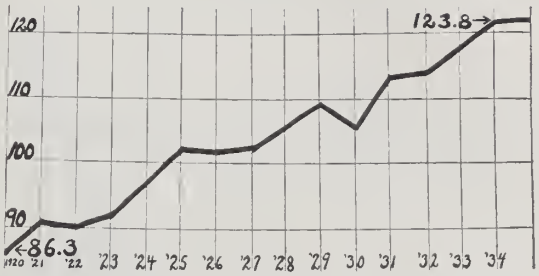


Chart 3.—Cancer mortality rates per 100,000 population from 1920 to 1935.

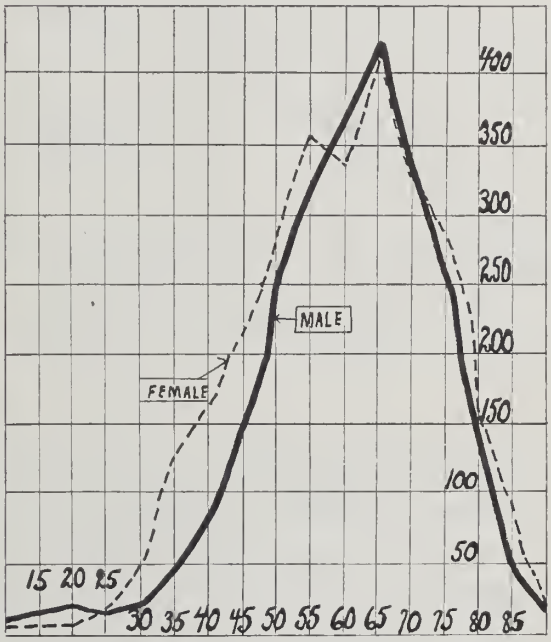


Chart 4.—Deaths from cancer in New Jersey per 100,000 population in each age group of five-year periods in 1935.

The death rate has risen from 86.3 in 1920 to 123.8 in 1935.

Chart 4 shows the number of New Jersey residents dying from cancer in each five-year age groups. The rate rises rapidly with the age of the person, and reaches its maximum at 65 years.

Chart 5 shows the number of people living in New Jersey who are 65 or more years of age according to census figures; and also giving estimates up to the year 1960. The age group of 65 years and over is increasing much faster than the total population.

It is of relatively little importance whether cancer is actually increasing; or the increased number is due to better diagnostic methods, plus an increase in the adult population of New Jersey. The fact still remains that each year cancer brings an increasingly large number of people to death's door. During the past fifteen years there has been an increase in the cancer mortality rate from 86.3 per 100,000 general population, to 123.8 per 100,000 general population. With the disproportionate increase of our adult population, we have every reason to believe that the cancer mortality rate in New Jersey will reach the unbelievable rate of 375 per 100,000 general population within the next fifteen years.

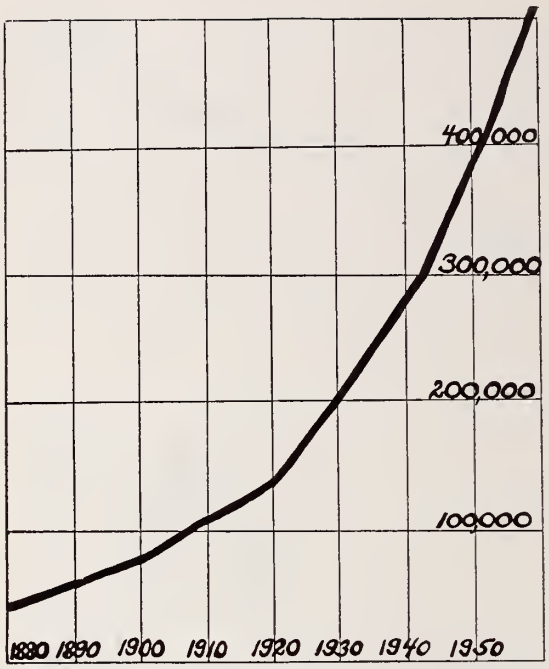


Chart 5.—Population of New Jersey at 65 years of age and over—1880-1930, with estimates to 1960.

If we do not prepare for this tremendous medical problem, we may rest assured that various voluntary lay organizations will organize to manage it for us. We have seen this in the field of tuberculosis. Why can't we be the leaders in cancer control? We have the technical knowledge, and a true understanding of its manifold problems. What we need to do is to organize our forces along lines we consider best, and the public will respond to our call. There are literally hundreds of honest, public-spirited people just waiting for our leadership. It would be a tragedy if this opportunity should go unanswered. We hope to submit a plan for this as a supplementary report.

SURVEY OF HOSPITALS

We have completed a survey of hospitals in the State, and Chart 6 shows a résumé of the findings. The report of the survey was published in The Journal of February, page 114, and we feel that the tables should be published in full as rendered in the report.

COUNTY CANCER HOSPITALS

Senate Bill 54, which was introduced by Senator Clee on February first, would enable the Freeholders of any county to build, equip,

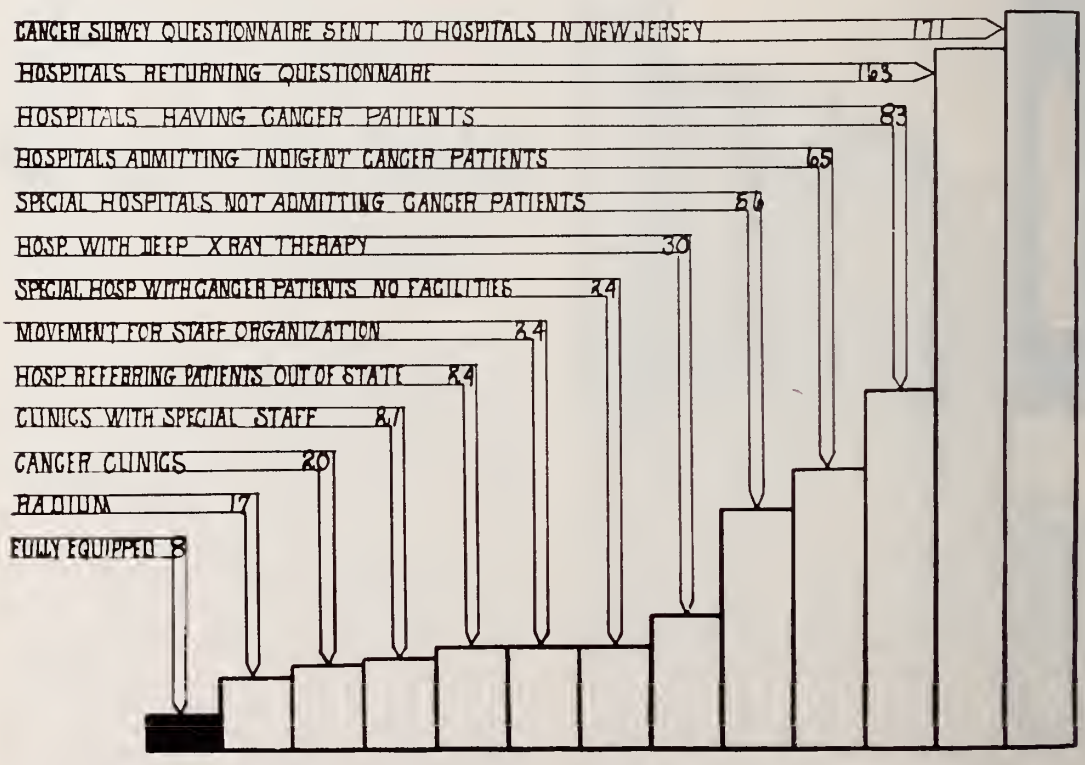


Chart 6.—Summary of hospital survey of New Jersey made in 1936.

and maintain a hospital for diagnosing and treating cancer patients.

The Cancer Committee, meeting on March 15, disapproved the bill for the following reasons:

1. The bill as prepared is very faulty, unworkable, and too expensive for application.
2. It gives the Freeholders of every county in the State, wherever in their judgment and the public needs require it, the right to build a hospital, and the medical profession need not be considered.
3. The Freeholders may erect a building or buildings for a hospital for the disease commonly called cancer, and to furnish and maintain the same.
4. The bill says nothing concerning treatment.
5. That the disease commonly called cancer is hereby construed to come within the meaning of contagious or infectious disease.
6. To classify cancer as contagious or infectious is not classifying it according to the understanding of the medical profession. No compelling proof has ever been presented that it is either infectious or contagious.
7. For cancer to be so labelled, every patient who has it would be liable for isolation; not being permitted to be in public places, etc.
8. There is no reason to doubt that, if this bill is enacted, it would permit Freeholders to build hospitals in the twenty-one counties. That in itself would be an item of tremendous expense, and to acquire land, to build, to furnish and equip the hospitals for treatment (which was not mentioned in the bill) would be an unwarranted expense for the taxpayers when the State itself cannot take care of the indigent at the present time.

FINANCIAL OBJECTIONS TO THE BILL

1. With over 5,000 deaths from cancer in the State last year, the necessary amount of radium required to properly treat cancer would be at least two grams, at a cost of $154,000 for each 1,000 deaths; and that would be ten grams for the State at an approximate figure of $770,000.
2. If there are no buildings available, and it is necessary to build, we question very much if a hospital of approximately 100 beds could be constructed under $200,000, which would amount to $4,200,000 for construction of hospitals in each county. This does not include purchase of land.
3. X-ray machines would cost $168,000. Maintenance of a hospital of seventy-five beds per year would cost approximately $130,000, or $2,730,000 for the State.
4. If each county had two grams of radium, it would cost $3,234,000. This would mean forty-two grams of radium for New Jersey alone, and there is only a little over 800 grams in the world. Therefore, it would be almost an impossibility to put radium in every hospital in the State. With these figures, it gives a total of at least $10,332,000.

If the members of the Essex County Medical Society wish their Board of Freeholders to establish a hospital for the diagnosis and treatment of cancer in Essex County, there should be no bar to their wish, provided the bill is so worded to eliminate the objections named above.

We wish to take this opportunity to thank Dr. Frankel, of the Department of Institutions and Agencies, for his coöperation in preparing charts and statistics of cancer for the entire State.

Respectfully submitted,

HENRY B. ORTON, *Chairman*
JOHN F. CONDON
E. E. DOWNS
J. H. KLER
CARL H. MENGE
F. C. MCCORMACK
JAMES H. ROSECRANS

REPORT OF THE ADVISORY COMMITTEE ON VENEREAL DISEASE CONTROL

By Charles H. deT. Shivers, M.D., Atlantic City, N. J.

To the Welfare Committee:

Venereal Disease Control is the newest activity to be undertaken by The Medical Society of New Jersey. The Advisory Committee on Venereal Disease Control was instituted in the Summer of 1936, and held its first meeting on September third. It recognized the newness and novelty of its objectives, and discussed measures which it should undertake.

The committee recognized at the outset that its scope embraced two groups of workers:

1. Family Doctors.
2. Organizations, led by the State Department of Health and the United States Public Health Service, as expressed in the Federal Social Security Act.

Two routes of approach to the problem presented themselves:

1. The private practice of general practitioners.
2. Official action by the State and the National governments.

THE HANDBOOK ON PREVENTIVE PROCEDURES

The committee first approached the subject by contributing a chapter on Venereal Disease Control to the "Handbook of Preventive Procedures to Be Undertaken by the Family Doctor", which was published as a supplement to The Journal of March, 1937. The committee hereby submits Chapter Nine of the Handbook as its report on the essential services to be rendered by the Family Doctor, and the methods of their delivery.

DIFFICULTIES TO OVERCOME

The committee is now considering the means and methods by which general practitioners of medicine may engage in treating venereal diseases. It recognizes the following general facts:

1. The whole subject of venereal disease control is in the same state that tuberculosis control was in the first decade of this present century; and a new system of action, somewhat similar to that in tuberculosis, will have to be devised.

2. Family Doctors do not now have, on a scale commensurate with the prevalence of the diseases, the office equipment, nor the expert diagnostic and therapeutic knowledge that are required in handling patients with venereal diseases.

3. The people generally are ignorant of the whole subject of venereal disease control, and still consider it from a *moral* rather than a *medical* standpoint.

PROPOSALS BEFORE THE COMMITTEE

At its first meeting, the committee gave careful consideration to the proposals of the official agencies regarding venereal disease control, including the following suggestions:

1. That a committee on venereal disease control be appointed in every county society.
2. That clinics be set up for the benefit of one class of patients—the indigent.
3. That physicians serving in the clinics be paid.
4. That local educational and case-finding facilities be extended by the State Department of Health.
5. That local diagnostic facilities be improved, and additional ones provided.
6. That the principles of the control of common communicable diseases be put into operation in venereal disease control.
7. That the pamphlet "Minimum Office Procedure", for the prevention and treatment of one phase of venereal disease—that of congenital syphilis—be distributed by physicians throughout the State.
8. That only the necessary and more economical drugs be made available to physicians, —and those be for the benefit of indigent cases only.

It was the opinion of the committee that while these measures were incomplete and dealt with only a small part of the field of venereal disease control, yet they should be approved as a beginning of the work.

DIFFICULTIES ENCOUNTERED

1. *Clinics.*—What should be their object? diagnostic? therapeutic? teaching?

The appointment of directors.

The kind of patients to be admitted.

The kind of service to be rendered.

2. *Diagnostic Centers.*—Darkfield diagnosis of syphilis? Kind of patients to be served? Free or pay services?

3. Reporting cases to the State Department of Health,—by number? or by name?

Follow-up of patients in the infectious stages of the disease.

4. The question of gonorrhoea—shall it be included in the clinic service?

5. The opposition of physicians to free services to those able to pay something?

6. Drugs supplied,—to be for indigents only? or for everybody?

These are examples of the difficult problems with which the committee has had to deal.

RECOMMENDATIONS

The committee makes the following recommendations to the House of Delegates:

1. The reporting of venereal disease cases to the State Department of Health be made by number or diagnosis, and not by name; and that this change in the law be made.

2. A program of education for the public as to the value of prophylaxis be instituted.

3. Drugs for the treatment of venereal diseases be supplied free by the State Department of Health upon request to any physician regardless of the patient's ability to pay.

4. Directors of venereal disease clinics shall be nominated by the county society and approved by the State Society, and on these certifications shall be appointed by the State Department of Health.

The committee approved in principle the following requirements of physicians in charge of clinics:

a. Clinicians should treat only patients referred by the local or State Health Departments who are indigent or semi-indigent, except for the first treatment, which should be given regardless of any consideration to any infectious patient preliminary to referring such patient to a private physician, if he can pay.

b. Adequate case records must be kept, and all cases must be reported by name and address to the State Department of Health, according to law. A monthly report on the form enclosed must be sent to the State Department of Health, a copy of which is forwarded to the U. S. Public Health Service.

c. Drugs will be supplied by the State Department of Health upon request to all new clinics for at least the first year of operation.

d. Necessary syringes and needles also will be supplied. Ability of the State Department of Health to supply drugs after the first year of operation is dependent upon State and Federal appropriations. The drugs are to be administered as recommended by the State Department of Health or the Coöperative Clinic Group of the U. S. P. H. S.

e. Information about the patients, names of delinquent patients, names of sources of infection shall not be given to anyone by any worker in the clinic, except with the approval in writing of the physician in charge of the clinic. It is expected, however, that the clinician will make every effort to get from the patient the name of the source of infection and contacts and report it to the State Department of Health, where the information will be forwarded to the local health officer for investigation. Delinquent patients also must be reported to the State Department of Health or directly to the local health officer.

5. That a program of education for the public as to the value of prophylaxis be instituted.

6. That a sub-committee on venereal disease control be appointed by the President of each county medical society to include any local medical health officer.

7. That every effort be made in the venereal disease clinic to limit as far as possible the treatment to patients presenting infectious states, and who are unable to pay the fee of a private physician. The general policy of limiting free treatment to indigent and marginal cases in clinics applies to patients not in the infectious stage.

8. That in the clinics physicians shall be paid for their services.

9. That local educational and case-finding programs now in progress, under supervision of the Bureau of the State Department of Health, be continued and augmented.

10. That local darkfield facilities be improved, according to recommendations of State Bureau on Venereal Disease Control, by establishing this service when it is needed and is not available.

11. That an attempt be made to investigate and correct delinquency among venereal disease patients in private practice, but that no State-wide plan be adopted until it has been tried and found workable in some county or smaller community.

12. That the pamphlet "Minimum Office Procedure for the Prevention and Treatment of Congenital Syphilis" be approved by the State Medical Society and distributed to physicians throughout the State.

13. That only the necessary and more economical drugs be made available by the Bureau of Venereal Disease Control to all private physicians for the treatment of indigent patients.

Respectfully submitted,

C. H. DeT. Shivers, *Chairman*
Stanley R. Woodruff
Clarence O'Crowley
C. Byron Blaisdell
George N. J. Sommer
A. Haines Lippincott

REPORT OF THE ADVISORY COMMITTEE ON MENTAL HYGIENE

By James S. Plant, M.D., Newark, N. J.

To the Welfare Committee:

The object of the Advisory Committee on Mental Hygiene is to promote the active interest of all practicing physicians not only in the abnormal mental states of patients but also in the fact that there are important and extensive mental factors involved in every physical illness.

SCOPE OF THE COMMITTEE'S FIELD

Every physician obviously practices mental treatment, finding that his main task is frequently that of inspiring his patients with confidence and allaying their fears. He often may disclaim a knowledge of mental hygiene, and may ascribe his success to the exercise of "common sense", but he nevertheless is actually treating the minds as well as the bodies of his patients. This imposes upon the Committee on Mental Hygiene two tasks.

1. The committee must spread correct conceptions as to the character and treatment of the various abnormal mental states. The committee here expects the general practitioner of medicine to enter the field of insanity, mental defect, epilepsy, and other "nervous states",—at least to the extent that he is acting in surgery, in cardiology and in other physical specialities.

2. The committee must bring to the attention of the practicing physician the facts:

a. That every illness is an emotional experience which *means* something special and different to each patient—that the place which the illness (actual, or supposed, or simply magnified) plays in the total adjustment of the patient to his surroundings is of immense importance.

b. That the patients of today are faced with unprecedented problems in social adjustment, which they are bringing to the physician either in the form of a direct request for his help, or disguised under a cloak of physical illness. The committee feels that where in earlier years the patients went to other professional groups (notably the church) for this help, they are now very largely seeking it from the practicing physician when he is at all willing or able to respond.

The general practice of mental hygiene is in its infancy so far as known principles of diagnosis and treatment are concerned. It is perhaps at the place that the whole field of public health was a generation ago. While it is to be noted that this field of public health has instituted certain new and unpredicted technics, it has very largely developed through a crystallization and a strengthening of those "common sense" attitudes about healthy living that a great number of people have. Similarly, mental hygiene probably for some time will represent a strengthening and clarification of the so-called "common sense" attitudes of a great many physicians. It may in time develop certain technics of its own.

In investigating the reason for the slow progress in the general practice of mental hygiene by family doctors (in comparison, for instance, with the rest of the field of public health), one fact must be considered. A very fair part of medical treatment involves drugs and physical treatment which easily lead the patient to feel that the doctor is "doing something for him".

In the field of mental health it is very largely the problem of the patient's doing something for himself. The patient lacks the feeling of safety that comes from actual dosage, and often resents any sort of implication that he has a part in the therapy when he had come looking only for external help. The practicing physician still will note that medicine in the physical field has begun to realize that it cannot cure people but that it puts their bodies in such good condition that they can cure themselves. On this basis the field of mental hygiene has no apologies to offer for the extent to which it imposes upon the patient the task of achieving or maintaining mental health.

Consideration must also be given to the fact that the treatment of crippled conditions of the body is considered satisfactory and honorable when even only a certain fraction of normal function is restored; whereas people at the present time are not satisfied with anything short of complete restoration of normal mental function. The need here is that we all get away from the fallacy that the psychiatrist can make an adjustment of the problems of people. We must all learn that, in the mental field just as well as in the physical, the goal is that of adjustments *to* problems (adjustment to the fact that we have problems) rather than the adjustment *of* problems.

THE FAMILY DOCTOR AND THE NERVOUS STATES

Doctors generally do not give a great amount of time and thought to a careful analysis of the mental states of their patients, relying on an intuitive knowledge of "human nature", which is perhaps as likely to be wrong as right. Out of the knowledge which psychiatrists bring from acute mental states and out of the knowledge which the general practitioner brings from actual dealing with patients, mental hygiene must seek to clarify and strengthen what is found to be worth while and sound in this "intuitive knowledge". The development of mental hygiene is absolutely a coöperative enterprise involving the experience and life of every practicing physician,—and is not, by any means any set of principles and technics discovered by a certain group, to be ladled out to the whole medical profession.

The people look to the family doctor for advice regarding mental states as well as physical conditions; and the mental hygiene committee attempts to acquaint the general practitioner with all of those facilities which are available for the treatment of such conditions.

The people, caught up in the terrific personal and family problems involved in rapid urbanization, the problems of new inventions, the helplessness of individuals in the growing strength of the social trends, look to the family doctor for advice regarding their adjustment. The family doctor cannot escape this responsibility, particularly as these fundamental problems and social adjustments are inextricably intertwined with the appearance, or with the stubbornness, of all sorts of manifestations of physical disorder.

With a very marked decrease in the time demanded for the *mechanics* of living, our people have become interested in the *relationships* of living. So the mother today is not half so much interested in the fact that John did not eat his spinach as in the question as to why he didn't eat it. People are asking the family doctor, "What does this mean?" "Why did it happen?" The Committee on Mental Hygiene does not now have answers to these questions; but it feels that it and the family doctor must develop answers to these questions if the latter is to maintain the confidence of his patients. It insists that here again is the necessity for the development of a body of knowledge which is to come in part from the expert on abnormal mental states, and in part from the knowledge of the general practitioner.

The Medical Society of New Jersey is considering the problem of the diagnosis and treatment of abnormal mental states by the family doctor, with the prospect of a degree of success comparable with that attained in the prevention and cure of physical abnormalities. The Medical Society of New Jersey is also considering the problem of diffusing throughout its entire personnel the knowledge and insight which many of its physicians have as to the extent to which the problems of social adjustment and of personal relationship seriously affect the origin and cure of physical troubles. The Medical Society of New Jersey does not consider this latter "task" as so much a new venture as it is now the matter of developing within every doctor the attitude which was forced upon the family physician of two generations ago who had to see his patients in terms of their total family and social adjustments. The Medical Society of New Jersey is thus considering the problems in physician-patient relationship that have naturally arisen from the tendency toward specialization in medicine, the rapid growth of laboratory technic and the lack of personal acquaintanceship which has come out of the rapid development of city life. These developments have forced upon the physician an attitude of seeing only the patient's illness instead of the patient himself.

DEFECTS IN THE PRESENT SYSTEM OF DEALING WITH NERVOUS STATES

The first essential in devising a practical plan in dealing with problems in the broad field of mental hygiene is to survey the defects in the attitude which now prevails amongst physicians and people towards abnormal mental states.

ATTITUDE OF FAMILY DOCTORS

The present attitude of the average family doctor is unsatisfactory in six respects:

1. He thinks in terms of fully developed mental states,—insanity, mental deficiency, unsocial behavior, epilepsy—and when these appear, is inclined to shun responsibility by referring the patients to psychiatrists in mental hospitals and state institutions.

2. He is annoyed by the complaints of neurotics and dismisses them with scant attention, as if these conditions could be controlled by the patients without his help.

3. He does not take an interest in mental pathology, and does not read practical articles on the subject—being therefore unprepared to deal with the early stages of abnormal mental states.

4. He believes that his patients will not adequately reimburse him for the time that it would take to uncover unhappiness and maladjustments that lie back of the physical illness. Moreover, he feels that patients would

resent this sort of probing when they have so clearly presented to him for treatment some concrete physical trouble.

5. The family doctor is actually aware of many of the real problems which he himself has and which he is not at all solving for himself. He thinks (or realizes) that when he goes into this field his position of authority and of "knowing more than the pateint", which is extremely important in the doctor-patient relationship, is very much threatened.

6. He usually refuses to continue to deal with the "uncoöperative" patient, failing to realize that this state of mind is one of the most important of the symptoms which he has to understand and cope with.

ATTITUDE OF SPECIALISTS IN MENTAL DISEASES

1. Most psychiatrists are connected with public hospitals conducted by the State; and they constitute a group which is to a great degree apart from practitioners in other fields.

2. Psychiatrists in geenral are dealing with rather advanced and frank mental breakdowns without a great deal of information or training in the handling of the very early symptoms. They thus tend to lose sight of the social settings which are so important in the early stages of maladjustment.

3. Due to these two factors the psychiatrist has tended to hide his insecurity behind a rather formal language which the family doctor does not understand. The terms which the psychiatrist uses are highly technical, and seem just mere words to the practicing physician.

ATTITUDE OF PATIENTS

1. Patients to a large extent resent the suggestion of their need of mental treatment. This is striking in view of the pride with which many of them recite their symptoms and experiences in the physical field.

2. This situation leads "nervous" patients to pinning their faith upon prescriptions and other material administrations. While these individuals often primarily need hope and courage and faith, it is not deemed "proper" that they seek these attitudes as such. This obviously leads to the development of all sorts of chronic and stubborn physical disabilities, and to an unquenchable thirst for every sort of material administration.

ATTITUDE OF PEOPLE GENERALLY

1. People generally do not comprehend the nature of abnormal mental states, but think that a defect in one line means mental incompetence in all lines of thought.

2. People associate the modern mental hospital with the custodial sort of "bedlam" which it probably was 100 years ago. To a large extent they are unaware of the marvelous advance in happiness, in therapy and in the provision of a proper mode of living that these hospitals have made during the last generation.

3. People look upon abnormal mental states as a disgrace, and discourage patients from seeking advice in this field. They believe that the only cure is that the patient will be sent to a mental hospital which they fear and dislike.

THE FIELD OF THE COMMITTEE ON MENTAL HYGIENE

The Committee on Mental Hygiene hopes during the coming years to develop a comprehensive plan of action to be put in effect by the Medical Society of New Jersey, and its component County Societies and their members, in order to answer the implications that run all through the previous sections on diagnosis.

The Committee on Mental Hygiene suggests the following program which it divides definitely into two part:—

1. It outlines here the present task to be done.

2. It believes that the steps to follow this first task will have to show themselves as the first task works itself through.

1. BY THE COMMITTEE ITSELF

a. That the committee be allowed to continue in something like its present form; that it serve as a clearing house for information as to the development of the program outlined below; and that it assume responsibility for indicating the weak points that appear as that program develops.

b. That the committee constantly stress its belief that the program can only be "put over" to the physicians through a "case study" method. Obviously this demands the strengthening of the present program of mental hygiene clinics.

c. That the committee constantly struggle for the principle that mental hygiene clinics shall be established only under these conditions:—

1. That every opportunity is utilized to show the local physician that the mental hygiene clinic is an agency to *help* him with his problems, rather than one to compete with him.
2. That the local group (city, county, or group of counties) show its willingness and ability to assume progressively more and more of the cost and support of such clinics.

COMPLETE DISPLAY

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SEASONABLE

AN EFFECTIVE TONIC AND VEHICLE

Prescription No. 13 **Glycerinated Elixir of Gentian**

May be prescribed by title as follows:

℞

	Metric	Apoth.
Elix. Gentianae Glycerinati, N. F.	250 cc.	ʒ viii

Sig: (as below)

May also be prescribed by listing ingredients as follows:

℞

	Metric	Apoth.
Fldext. Gentianae	2.5 cc.	m xL
Fldext. Taraxaci	3.75 cc.	ʒ i
Tr. Cardam. Co.	15. cc.	ʒ iv
Syr. Rubi Idaei	15. cc.	ʒ iv
Tr. Aurant. Dulc.	3.75 cc.	ʒ i
Acidi Phosphorici	1.25 cc.	m xx
Aethylis Acetatis	0.25 cc.	m iv
Glycerini	100. cc.	ʒ iii ʒ ii m xL
Sucrosi	50. Gm.	ʒ i ʒ v
Alcoholis	25. cc.	ʒ viss
Aqua Dest., q.s.	250. cc.	ʒ viii

Sig: Two teaspoonfuls as required.

A TONIC ELIXIR

Prescription No. 14 **Elixir Calisaya, Alkaloidal**
Elixir of Cinchona Alkaloids

May be prescribed by title as follows:

℞

	Metric	Apoth.
Elix. Cinchonae Alkaloidorum, N. F...	250 cc.	ʒ viii

Sig: (as below)

May also be prescribed by listing ingredients as follows:

℞

	Metric	Apoth.
Quininae Sulf.	0.5 Gm.	gr. viiss
Cinchonidinae Sulf.	0.25 Gm.	gr. iv
Cinchoninae Sulf.	0.25 Gm.	gr. iv
Tr. Persion. Co.	12.5 cc.	ʒ iiss
Elix. Aromat., q.s.	250. cc.	ʒ viii

Sig: Two teaspoonfuls as required.

A HAEMATINIC TONIC

Prescription No. 15 **Solution of Iron Peptonate and Manganese**

May be prescribed by title as follows:

℞

	Metric	Apoth.
Liq. Ferri Peptonati et Mangani, N. F..	250.0 cc.	ʒ viii

Sig: (as below)

May also be prescribed by listing ingredients as follows:

℞

	Metric	Apoth.
Ferri Peptonati	4.375 Gm.	ʒ i
Mangani Citratis Solubilis	2.18 Gm.	ʒ ss
Ol. Aurantii	0.0375 cc.	m ss
Aethylis Acetatis	0.05 cc.	m i
Vanillini	0.005 Gm.	gr. 1/13
Alcoholis	37.5 cc.	ʒ i ʒ ii
Syrupi	12.5 cc.	ʒ iiss
Glycerini	12.5 cc.	ʒ iiss
Aqua Dest., q.s.	250.0 cc.	ʒ viii

Sig: Two teaspoonfuls as required.

Sele

THE JOINT C
PROFESSION

consisting of the Committee on Pl
Society of New Jersey and the C
the New Jersey Pharmaceutical
for non-proprietary, ethical comb

The prescriptions presented t
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pound".

Prescription No. 13 is the Na
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Prescription No. 15 is the Na
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proprietary preparation of Peptor

Prescription No. 16 represe
Quinine, Strychnine and Arsenic
often referred to as Aitken pills.

Prescription No. 17 is the Na
Hypophosphites, which is similar
familiar to the profession and to

Prescription No. 18 is the re
Syrup of Ammonium Mandelate",
O. U. Sisson. In this formula eac
of Mandelic Acid and 0.75 grams
of Mandelic Acid are now being
pyelitis and similar conditions.

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asthma and hay fever.

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RESCRIPTIONS

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)IMITTEE ON RELATIONS

ceutical Problems of The Medical tee on Professional Relations of ation, to meet the requirements s of useful drugs.

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Formulary Elixir Gentian Gly- dients as a well-known proprie-

wn Elixir of Cinchona Alkaloids. Elixir Calisaya. Its tonic proper- th Iron Salts, if desired.

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e popular combination of Iron, l form. This is the prescription

Formulary Compound Syrup of ie well-known proprietary syrup iblic for many years.

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ESCRIPTIONS

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maceutical Problems of New Jersey

ER, M.D., Gibbstown, Chairman
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SEN, M.D., Passaic
ANN, M.D., Union City

A HAEMATINIC TONIC IN PILL FORM

Prescription No. 16 — **Aitken Pills**

May be prescribed by title as follows:

℞ Pil. Ferri, Quininae, Strychninae et Arseni, N. F.
Mitte no. 100
Sig: (as below)

May also be prescribed by listing ingredients as follows:

℞	*Metric*	*Apoth.*
Ferri Reducti	4.50 Gm.	ʒ i gr. x
Quininae Sulf.	6.50 Gm.	ʒ i gr. xL
Strychninae	0.13 Gm.	gr. ii
Arseni Trioxidi	0.13 Gm.	gr. ii
Glucosi, q.s. ft. pil. no. 100		

Sig: One pill as required.

A POPULAR TONIC

Prescription No. 17 — **Compound Syrup of Hypophosphites**

May be prescribed by title as follows:

℞	*Metric*	*Apoth.*
Syr. Hypophosphiti Co., N. F.	250. cc.	℥ viii

Sig: (as below)

May also be prescribed by listing ingredients as follows:

℞	*Metric*	*Apoth.*
Calcii Hypophosphitis	8.75 Gm.	ʒ ii gr. xv
Potassii Hypophosphitis	4.375 Gm.	ʒ i
Sodii Hypophosphitis	4.375 Gm.	ʒ i
Ferri Hypophosphitis	0.55 Gm.	gr. viii
Mangani Hypophosphitis	0.55 Gm.	gr. viii
Quininae	0.275 Gm.	gr. iv
Strychninae	0.025 Gm.	gr. 2/5
Sodii Citratis	0.925 Gm.	gr. xiv
Acidi Hypophosphorosi	1.25 cc.	min. xx
Sucrosi	175. Gm.	℥ v ʒ vii
Glycerini	12.5 cc.	ʒ iiss
Aqua Dest. q.s.	250. cc.	℥ viii

Sig: Two teaspoonfuls as required.

A MANDELIC ACID PREPARATION

Prescription No. 18 — **Compound Syrup of Ammonium Mandelate (Fantus)**

May be prescribed by title as follows:

℞	*Metric*	*Apoth.*
Syrupus Ammonii Mandelici	250. cc.	℥ viii

Sig: (as below)

May also be prescribed by listing ingredients as follows:

℞	*Metric*	*Apoth.*
Saccharini Solubile	0.250 Gm.	gr. iv
Ammonii Chloridi	12.500 Gm.	ʒ iii ss
Ammonii Carbonati	20.000 Gm.	ʒ v
Acidi Mandelici	50.00 Gm.	ʒ i ʒ v
Sucrosi	100.00 Gm.	ʒ iii gr. CLX
Benzaldehydi	0.010 cc.	m 1 6
Ol. Foeniculi	0.025 cc.	m 2 5
Anetholi	0.25 cc.	m iv
F. E. Glycyrrhizae	43.75 cc.	ʒ i ʒ iiss
Aquae q.s.	250.00 cc.	℥ viii

Sig: 15 cc. as directed.

3. That the Directors of such clinics be of the type that will use the clinic material to elicit and strengthen the mental hygiene attitudes already present in the community. These clinics must be teaching clinics in the widest and best sense of the word.

d. That the committee from time to time shall be responsible for presenting to the editor of The Journal of The Medical Society of New Jersey articles of two sorts:

1. Those dealing with the mechanics of commitment to the mental hospitals and with the handling of acute mental disturbances; and
2. Those dealing with the mental hygiene aspects of the usual social and family adjustments of individuals. The committee is however, certain that this material is of little value in areas where mental hygiene clinics are not presenting actual clinical evidence of what can and cannot be accomplished in such cases.

e. That the committee should watch, as far as it can, the development of lecture programs before the county societies and allied groups—particularly to be on guard that the mental hygiene program shall not be "sold" beyond the ability of clinicians within any area to demonstrate the ways in which it can be of assistance.

2. BY PSYCHIATRISTS

a. Stress, in every feasible way, that the mental hygiene clinic is a helpful tool to the family doctor, and that it does not compete with his practice. In fact the clinics now in existence have increased and enriched the work of the general physician.

b. Develop as seems best some method by which at periodic times the family doctor of each inmate of an institution shall be informed about the progress of the patient. A technique should be developed here that uses the patient as a means of educating the doctor as to the whole field of mental diseases. That is, we are not here so much interested in an actual objective report as we are in showing:

1. The friendly attitude of the hospital;
2. The extent to which the patient is finding answer to his fundamental needs in the hospital;
3. The extent to which his ailment was really presenting an answer on his part to a social environment and set of problems which he found baffling.

Probably also here should be developed some scheme by which knowledge of discharge of the patient and suggestions for continuing his treatment in the community by the doctor can be given to the family doctor by the hospital. Probably this should include institutions for mental defect quite as much as those for mental disease.

c. Coöperate with the family doctor in obtaining voluntary consents of mental patients to go to institutions for mental treatment. The psychiatrist should not only aid the doctor with his particular cases, but also, in his own peculiar way, should use this as a means of showing to the family physician the values of early hospitalization and the general types of approach that are to be made in changing the public's attitude toward hospitalization.

d. Cultivate the friendship and confidence of the family doctor, and make every invitation that he bring his problems—and indeed patients—to the institution for private examination and friendly advice.

3. BY THE COUNTY SOCIETY

a. Appoint a committee on Mental Hygiene, to work in coöperation with the State Committee.

b. Coöperate with the State Committee in arranging for lectures and demonstrations where there is genuine interest in a local mental hygiene unit that is actually operating.

c. Make contacts with the most available mental hospitals, and arrange with their staffs for examining and treating patients either at their homes, or as voluntary patients in the institution.

d. Develop a program involving service clubs, parent-teacher associations and other such groups that will make them aware of the value of early diagnosis and treatment of unusual mental conditions.

The County Society should never undertake such a program of instruction until it is provided with the proper facilities for handling such situations. One of the worst things that has happened with the mental hygiene program has been its initiation of interest in problems which we were not equipped to handle.

e. Exert such pressure as it can on public officials towards the continuance and strengthening of adequate facilities for case demonstration of the mental hygiene field and point of view.

4. BY THE FAMILY DOCTORS

a. Meet the psychiatrist half-way in his effort to give instruction and assistance in handling mental disorders.

b. Become definitely acquainted with men-

tal institutions and clinics in his neighborhood. This ought to involve actual visitation.

c. Follow up the patients whom he sends to public institutions.

d. Consult the nearest of the following list of aids in this matter when in need of advice or assistance.

State Hospital for Mental Diseases, Greystone Park, Morris County. Dr. Marcus A. Curry, Superintendent. Telephone Morristown 4-1800.

State Hospital for Mental Diseases, Trenton, N. J. Dr. R. G. Stone, Medical Director.

State Hospital for Mental Diseases, Marlboro, Monmouth County. Dr. J. M. Gordon, Medical Director. Telephone Freehold 229.

Essex County Hospital for Mental Diseases. Dr. Guy Payne, Superintendent. Telephone Humboldt 3-1505.

Hudson County Hospital for Mental Diseases, Jersey City. Dr. A. D. Orr, Warden. Telephone Palisades 6-5100.

The State Village for Epileptics, Skillman, Somerset County. Dr. Dan S. Renner, Superintendent. Telephone Hopewell 181.

STATE INSTITUTIONS FOR THE MENTALLY DEFICIENT

State Colony for Feeble-Minded Males, New Lisbon, Burlington County. C. T. Jones, Ph. D., Superintendent. Telephone Pemberton 1.
For patients whose mental capacity is of a fairly high grade.

State Colony for Feeble-minded Males, Woodbine, Cape May County. Edward L. Johnstone, Superintendent. Telephone Dennisville 21.
For children of a low grade of intelligence, although many inmates have now reached mature ages.

New Jersey Training School, Little Falls, Passaic County. A. H. Meese, Superintendent. Telephone Little Falls 4-0800.
For feeble-minded females with a considerable degree of intelligence.

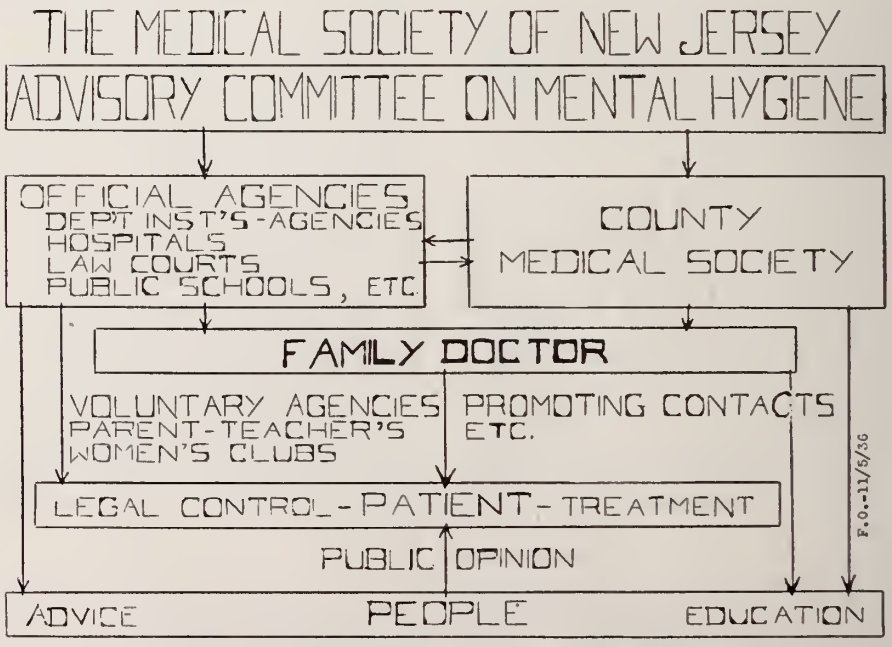
Vineland State School, Vineland, Cumberland County. George B. Thorn, Superintendent. Telephone Vineland 3.
For females of a low grade of intelligence.

In addition, several hundred mental defectives who are wards of the State are boarded in the Vineland Training School, of which Dr. Edward Johnstone is Medical Director. This institution is for both boys and girls, and receives those who have sufficient intelligence to respond to considerable training. It also conducts researches in problems of mental and unsocial behavior.

e. Assist, through ordinary office and social contacts, the county societies' efforts at removing the prejudice of people against the implications of mental diseases and hospitalization.

CHART OF RELATIONS AND CONTACTS

No plan of action is clear and comprehensible unless it can be visualized in a simple chart.



The relations of the Family Doctor to other agencies engaged in mental hygiene

The central agency in the accompanying chart is the Family Doctor. He is the natural medical advisor to the individual patients in *mental* abnormalities as well as *physical* conditions.

The family doctor will be in contact with two agencies:—

1. Official agencies, especially in insanity, mental deficiency, abnormal behavior, truancy, and crime. There are legal aspects in every severe case of mental abnormality, involving committments to institutions, divorces, family quarrels, and financial failures.

Official agencies will also be in contact with the people in giving advice regarding the needs of the services of their departments, and in securing appropriations and moral support.

2. The County Medical Society will be the agency through which the instruction and assistance will be made available to physicians, to voluntary agencies, and to the people.

The family doctor will be in immediate charge of the treatment of the patient, as he is in cases of appendicitis and pneumonia. He will call a psychiatrist in cases of mental disease, just as he would call a surgeon in suspected appendicitis.

The County Medical Society will be the agency through which the medical profession will make contacts with the official agencies, and will secure coöperation between all the groups interested in mental hygiene.

The fountainhead and director of all the medical activities connected with mental hygiene will be the Advisory Committee on Mental Hygiene of The Medical Society of New Jersey.

The plan that is outlined in the branch of mental hygiene is similar to that of advisory committee engaged in the delivery of services of medicine to those afflicted or threatened with physical ailments.

The plan also involves coöperation with the Sub-Committee on Public Relations in giving instruction to the people.

The committee recommends:

1. That the State Medical Society endorse the present policy of the State Department of Institutions and Agencies in establishing mental hygiene clinics that are associated with its State mental hospitals and which operate in the counties adjacent to those mental hospitals.

2. That the State Medical Society endorse the proposition that mental hygiene can be taught to the community and to the family doctor chiefly through the actual clinical work of these mental hygiene clinics. That is, that the State Medical Society endorse the proposition that lectures and articles on mental hygiene are relatively ineffective—and can only be made effective where the family doctor can have actual case experience with the mental hygiene clinic that serves his area.

3. That in view of the fact that the mental hygiene clinic operating from the Trenton State Hospital is under-staffed, and of the fact that the Marlboro State Hospital has not been able to establish such a clinic, and in view of the fact that the Princeton Survey strongly recommended an increase in these mental hygiene clinic facilities—the State Medical Society endorse any feasible movement towards increasing these facilities to the point that they at least meet the needs of the Trenton and Marlboro hospitals.

Respectfully submitted,

JAMES S. PLANT, *Chairman*
DAN S. RENNER
MARCUS A. CURRY
J. BERKELEY GORDON
MATTHEW MOLITCH
GEORGE S. STEVENSON.

REPORT OF THE ADVISORY COMMITTEE ON CONTRACT PRACTICE

By R. L. SHARP, M.D., Camden, N. J.

To the Welfare Committee:

The Contract Practice Committee finds that its task is much greater than was anticipated on undertaking this work. The conditions differ greatly in the various parts of the State, and the ramifications are quite numerous. Industrial jobs, school physicians, compensation work done on contract, and in certain localities lodge physicians, each present an individual problem.

In the set-up of our present compensation law, almost none of the industrial contracts fulfill to the letter the requirements laid down by the American Medical Association on Contract Practice. However, we feel that necessity has brought about some departures from the adherence to the letter which with our present compensation laws must be considered ethical.

The committee has unanimously agreed that the only way to arrive at any definite solution of this problem is to gather, first hand, from all licensed practitioners of medicine in the State of New Jersey, information concerning this subject. This will, of necessity, take some time, and can only be accomplished after much thought and study.

At the present time we are working on a preliminary draft of a questionnaire embracing the salient points to be covered, which we plan to carry out in one of the more thickly populated counties, probably through the County Society. If this proves satisfactory, it is the plan of the committee to undertake this work county by county, probably calling on the County Society or the Key Men in the various societies for their assistance.

We feel that while on the whole there are only a few willful flagrant violations; yet we also feel that, unless this practice be regulated and controlled by ourselves, eventually it will become a distinct menace to private practice.

Respectfully submitted,

R. L. SHARP, *Chairman*
EDWARD F. KLEIN
L. SAMUEL SICA
JOSEPH A. VISCONTI
L. A. MARKLEY
HARVEY T. HEROLD

REPORT OF THE ADVISORY COMMITTEE ON HOSPITAL RELATIONSHIPS

By T. K. LEWIS, M.D., Camden, N. J.

To the Welfare Committee:

Because of the fact that the returns of the Hospital Survey which was set in motion last fall have been somewhat slow in finding their way home, the work of this committee has really just begun. To date about 60 questionnaires have been returned. By far the most important part of this undertaking centers around the general hospitals, although considerable attention will be given to private, State, and Municipal institutions. Of approximately 60 general hospitals returns are in from 46. Many of these questionnaires are inaccurately or incompletely answered, and it will require several months to complete the compilation of data with sufficient accuracy to warrant a detailed summary or the formulation of trustworthy conclusions.

However, through careful analysis of the returns received to date, a few facts are obvious and the Committee believes that certain recommendations are timely, and need not be considered as premature.

CARE OF THE INDIGENTS

Analysis of the returns from the general hospitals, exclusive of those municipally operated, reveals the fact that more than half of the hospital dollar receipt is derived from paying patients; while more than half of the patients treated are in the charity wards.

It is further revealed that public funds do not pay much more than half for the hospitalization of the indigents, in most communities.

These two facts indicate that the unfortunate sick pay patient is taxed, over and above the cost of his own hospitalization, for the care of the poor, while the well portion of the tax-paying public gets off very nearly scot free.

HOSPITALS AND THE INDIGENT

It is the belief of your committee that the cost of the care of indigents should be paid by the public at large, on a state-wide plan, through some such set-up as that of the late

Medical E. R. A. The high spots of such a plan are as follows:

1. Adequate socio-economic investigation of all applicants for free medical service. (This to be provided for out of public funds.)
2. Remuneration to hospitals on a cost basis for full charity cases according to ward bed-day occupancy. Such a system will involve a careful auditing system, but need not entail any sort of political chicanery.
3. Encouragement of the continuation of private contributions which shall be used to supplement the cost of care of patients in the very low-wage bracket who can receive treatment in hospitals only in the public wards, at a rate below cost.
4. Modified pay by state relief funds to private physicians for treatment of the destitute in home or office.
5. Funds for such a service can be procured as in other States by a wisely administered luxury tax. Provided such tax parallels and coincides with systems operating in neighboring states, no hardships need be imposed upon the merchants of New Jersey.
6. In view of the fact that Newark has in operation already part of the all-inclusive system that is known as the Washington Plan, the committee recommends that the Medical Society of the State of New Jersey suggest to Commissioner Ellis that he request the Municipality of Newark to go all the way with this plan as an experimental test of its practicability.

HOSPITALIZATION INSURANCE

Hospitalization insurance has been in operation on a widespread basis in North Jersey and has met with considerable success as a means of assisting the hospitals, the patient, and the physician. It seems to go far toward solving the problem of furnishing medical care to individuals in the upper portion of the low-wage bracket. The committee stands firmly on the principle that under this insurance, the services of physicians must not be sold or included in the hospital fee. While cognizant of the fact that in the past and to a certain extent in the present this principle has suffered, yet time and experience have greatly modified the objections; and there is every indication that in the near future this one unsatisfactory phase will be removed.

The success of any such insurance venture depends upon numbers, for the larger the number of policy holders, the sounder will be the insurance. Therefore it is obvious that the home of any such insurance plans should be located in the larger metropolitan areas.

The committee recommends that this Society request that the set up in North Jersey be enlarged to extend out over the State.

CONTROL OF SURGICAL OPERATORS

From returns in the survey it is apparent that in almost every general hospital some effort is made to prevent the undertaking of major surgery and other special procedures by physicians not fully qualified. Such precautions are right and proper both for the protection of patients and the good name of the hospital. However, there is lacking uniformity in methods of control, with the result that considerable dissatisfaction has been expressed here and there, by both the laity and the profession.

It is the belief of the committee that the State Medical Society of New Jersey should formulate a concrete plan for proper control which will be framed so that, while affording protection to patients it will not be so exacting as to discourage the young physician in his surgical ambitions. If it is the will of this body, the Advisory Committee on Hospital Relationships will be prepared to present such a plan to the House of Delegates at the coming annual meeting.

Respectfully submitted,
T. K. Lewis, *Chairman*,
Edward W. Sprague,
Raymond J. Muller,
Russell K. Tether,
Florentine Hoffman,
E. W. Lance,
Charles B. Kelley,
Henry B. Decker.

REPORT OF THE ADVISORY COMMITTEE ON NURSING AND NURSING EDUCATION

By A. Charles Zehnder, M.D., Newark, N. J.

To the Welfare Committee:

The Advisory Committee on Nursing and Nursing Education reaffirms the fundamental principle that the Medical Profession is solely responsible both morally and legally for the medical care, treatment, and nursing of the patient. That Preventive Medicine as well as Curative Medicine is included in this responsibility.

With this fundamental principle in mind,

our committee has sympathetically considered the problems of the Medical Profession in relation to the Nursing Profession.

We present two important objectives for the consideration of our society.

THE REGISTERED NURSE

1. The didactic instruction for the Graduate, Registered Nurse should be given before the pupil nurse enters upon her bedside training,—thereby permitting the pupil nurse's bedside training to be uninterrupted by classroom work, except insofar as it is necessary to amplify the bedside instruction.

In regards to this first objective, that the Registered Graduate Nurse receive her didactic instruction of one or possibly up to two years before entering upon her bedside instruction, this plan would have the advantage of having the pupil nurse's bedside training uninterrupted while caring for the patient during the latter part of her training.

It might also reduce the cost of nursing to the hospital, and thereby reduce the cost of hospitalization to the patient.

The cost of nursing education is constantly increasing and is becoming a real problem for hospital authorities to consider. The new curriculum is planning to increase the classroom work and give less time in the ward, thereby increasing the cost of nursing to the hospital.

The quality of nursing education would be improved by having professional educators teach the student nurse during the didactic period of training. That the quality should be improved is shown by the Grading Committee's report of the American Nurses' Association, The National League of Nursing Education, and The National Organization for Public Health Nursing, in which they find as follows: "The majority of nursing schools in the country are mediocre schools and that there is no need for more graduate nurses with mediocre training and background." This finding is by the nurses' own committee.

At present there is a plan being developed to give two years of educational work in the State Normal Schools, followed by three years of nursing education in selected Nurses' Training Schools, after the completion of which the degree of Bachelor of Science in Nursing is given.

Our committee recommends that a copy of this plan be sent to the following:

a. The National Nurses' Association.

b. The National League of Nursing Education.

c. The National Organization for Public Health Nursing.

d. Every chapter of the N. J. Nurses' Association.

e. The Board of Trustees of every hospital in New Jersey.

The raising of pre-nursing educational requirements has undoubtedly limited the number of nurses entering training, and also developed the tendency for more and more of the graduate nurses to enter the industrial nursing field and the public health nursing field, thereby restricting the number of graduate nurses for bedside nursing in the home.

NURSING ATTENDANTS

This brings us to the second of our major objectives, namely the urgent need for nursing in the home at a lower cost than at present is possible. This could be accomplished by training nursing attendants.

There is a definite field and an urgent need for a nursing attendant to minister to the physical wants of the mildly sick; the post-operative home patient; the mother and new-born infant; the patient who is not seriously ill; and the aged. To supply this need, women between the ages of 21 and 45 years, and whose minimum of education is that of a grammar school, should be trained.

This special field of nursing should include simple nursing procedure, plain house work, cooking, and care of the well child. In other words, in addition to caring for the patient, the nursing attendant should be trained to manage a home in which there is no servant, or very little service.

The cost should be $18.00 to $21.00 per week.

MINOR RECOMMENDATIONS

Minor recommendations are:

1. All public health nursing should be done only under the supervision of a physician.

2. No school board should be allowed to issue printed prescriptions for distribution by nurses.

3. The rules and regulations for nursing services of departments of health and of schools in each county should be obtained and reviewed.

4. In regards to industrial nursing, the following is recommended:

In view of the fact that the doctor is legally responsible for all medical care, and that it has been called to our attention in many instances that nurses, and particularly industrial nurses, have practiced and are still practicing medicine in the legal sense, and therefore are liable for prosecution, we request that a letter be sent from The Medical Society of New Jersey to the State Organization of Nursing,

to each local nursing chapter or group, and to each County Medical Society, informing them and warning them against this practice.

5. In view of the fact that all nursing is done under the superviison of a doctor, who is responsible for the conduct of the case, we are opposed to a separate Board of Examiners for Nurses.

6. The committee unanimously disapproves of the proposal that a nurse be appointed to the New Jersey State Board of Health.

7. Finally, we suggest that the American Medical Association be requested to urge the appointment of a representative on the Committee on Curricula of the National League of Nursing Education. Also that the Medical Society of New Jersey request that a medical representative be appointed on the New Jersey State Board of Examiners of Nurses.

Respectfully submitted,

A. C. ZEHNDER, *Chairman*
DAVID B. ALLMAN
I. F. FROST
EDGAR A. ILL
H. WESLEY JACK
GEORGE M. KNOWLES
H. H. SATCHWELL

REPORT OF THE ADVISORY COMMITTEE ON MEDICAL CARE OF THE INDIGENT

By CHARLES H. SCHLICHTER, M.D., Elizabeth, N. J.

To the Welfare Committee:

Your committee has been working on this problem all Winter. It has had several meetings with the Director and the Assistant Director of the Finance Assistance Commission. We have discussed the manner of approach, and both sides finally concluded to accept the same agreement that was in force during the Emergency Relief Administration. This matter is now before the Finance Assistance Commission, which is awaiting the action of the Legislature as to available funds. The committee is now marking time and reports progress.

Respectfully submitted,

CHARLES H. SCHLICHTER, *Chairman*
GEORGE W. FITHIAN
A. HAINES LIPPINCOTT
J. HOWARD HORNBERGER
FRED VOSBURGH

REPORT OF THE ADVISORY COMMITTEE ON WORKMEN'S COMPENSATION

By J. IRVING FORT, M.D., Newark, N. J.

To the Welfare Committe:

During the past year our committee has made an intensive study of the Workmen's Compensation Act of our State from the standpoint of its medical provisions, with special reference to the administration thereof and the defects therein.

Our first meeting, held in September, 1936, was devoted to organization, and we decided to study our problem from various angles. We elected to obtain our information by means of the following plan:—

1. To contact the component county societies and request each society to discuss the questions involved, either in special committee or in general meeting, and to report to us its findings and recommendations:

2. To study the Compensation Laws of other States as to medical provisions;

3. To investigate through personal discussion with various individual members of our State Society;

4. To consider the recommendations of former "Committees on Compensation" of our own State Society, submitted in the past few years;

5. To endeavor to obtain the disposition of the Department of Labor, the employer, and the carrier, toward our efforts to improve the medical provisions of the Act.

In completing our plan considerable data has been obtained, studied, and digested; and after discussion, our recommendations are based on our findings as revealed by the situations which our information discloses.

The Committee, therefore, submits the following recommendations, with the suggestion that they be incorporated in an amendment to the present Compensation Law and submitted to our Legislature for passage at such time as the Legislative Committee of our State Society shall deem expedient.

A. We recommend the following procedures as relative to the treatment of an injured employee.

1. The employer and his agent, the insurance carrier, shall discontinue the treatment of compensation injuries and compensable occupational diseases, except in the consultant medical supervision.

2. The injured employee shall have the right to select his own physician, provided that such physician is a member in good standing of a component county medical society.

3. The employer or his agent shall have the right to select from members in good standing of a component county medical society, physicians of standing and experience, to consult with the attending physician in a given case and advise with him as to treatment.

4. If there is a difference of opinion as to diagnosis or treatment in a given case between the attending physician and the consultant for the employer, which can not be settled satisfactorily, the case shall be referred to the State Physician in the district of jurisdiction, who shall consult with the attending physician and the employers' medical adviser and render an opinion in the controversy, and a recommendation as to the disposition of the case.

5. No claim for medical or surgical treatment shall be valid against an employer or his agent unless the physician assuming the treatment of a compensable case shall, within seventy-two (72) hours after the initial treatment, send to the employer or his agent a written report which shall contain:—the name of the injured, the address of the injured, the date, time of day and place of the accident, or if occupational compensable disease, the approximate time of onset of symptoms, the history of the accident, the diagnosis of the condition in so far as it can be ascertained, the prognosis and probable length of treatment, and a preliminary estimate of temporary and potential permanent disability. Thereafter the attending physician shall render subsequent reports of the progress of the case at such times as the employer or his agent may so request in writing.

6. Within thirty days (30) after the completion of treatment the attending physician shall render an itemized bill for services rendered, to the employer or his agent and shall forward a copy of this bill to the Department of Labor, and it shall be the duty of the Department of Labor to file this copy with the record of the case for treatment of which the bill is rendered and no case shall be closed until such bill has been either paid or adjusted.

7. a. There shall be a "Bill Adjustment Committee" in each Compensation District to which all disputed bills shall be referred; and this Committee shall have power, after investigation, to adjust said disputed charges.

b. Each Bill Adjustment Committee shall be composed of three members, one selected by the State Medical Society on recommendation of a Component County Society, one selected by the employers as a group, or by their agents, who must also be a member of a Component County Society, and one, selected by the Department of Labor, who must also be a member of a Component County Medical Society.

c. The parties to these arbitration proceedings before the "Bill Adjustment Committee" shall pay to the Department of Labor a sum equal to five (5) per cent, of the amount payable under the decision, or a minimum of $2.50 each, which even is greater, and from sums so collected the Department of Labor shall pay to each committee member the sum of $10.00 per diem for expenses for each session attended.

8. a. Medical treatment by public hospitals maintained wholly or for the greater part by public taxation shall be limited to emergency treatment only, and then only so long as the immediate emergency exists, except in a locality where no other hospital exists other than one supported wholly or in greater part by public taxation and except that such public hospitals may treat their own injured employees if the injury requires hospitalization.

b. In hospitals other than those maintained wholly or in greater part by public taxation, a compensation case shall be treated by the physician to whom he is assigned under the regulations of such hospital by virtue of the nature of his injury or disease, and the physician to whom such case is assigned shall be bound by the same regulations as if he were the private attending physician of the injured party, except that any injured employee, suffering from a compensable disease, admitted to such hospital may at his own request be treated by a physician of his own choice, provided that such physician is entitled to the privileges of such hospital.

c. No portion of the fee for professional services rendered in a compensation case shall be diverted to the hospital itself, and no hospital shall render at any time a bill of charges for medical treatment.

B. We recommend the following procedures relative to adjudication of cases in the Department of Labor.

1. There shall be a complete separation of the legal from the medical questions pertaining to the determination of disability claims.

2. a. A primary hearing shall be held at which the Deputy Commissioner shall, after hearing such testimony as is necessary, decide the legal questions involved.

b. At such primary hearing there shall be presented by the State Physician a full medical report based on his own findings from examination of the injured employee and on the records of the case as submitted by the attending physician,

which report shall contain a determination of the temporary and permanent disability.

c. Both employee and employer, or his agent, may be represented at such primary hearing by the attending physician and the medical representative of the employer or his agent, and both such physicians may be consulted by the State Physician.

d. All proceedings of the primary hearing shall be stenographically recorded, and shall be part of the record; and all such records shall be forwarded to the Commissioner of Labor.

3. a. If after the determination of the State Physician at the primary hearing, there be a dispute on the part of the employee or the employer, an appeal may be taken from such determination to the Board of Medical Referees, which appeal shall be in writing setting forth the grounds for such procedure.

b. The Board of Medical Referees will hold hearings at designated times and places, will review all medical testimony as rendered by the attending physician and such consultants as were associated with him in the treatment of the injured employee, all medical testimony as rendered by the medical representatives of the employer, the determination of the State Physician who examined the injured at the primary hearing, and all records of the case which pertain to the medical questions involved.

c. At the conclusion of the hearing, the members of the Board assembled will make a complete examination of the injured employee and render an opinion in writing to the Commissioner of Labor; and this opinion shall be final in the Department.

d. The procedure of such meetings of the Board of Medical Referees shall be stenographically recorded and made a part of the records in the case.

C. 1. The Commissioner of Labor shall appoint State Physicians in sufficient number to carry on the medical work of the Department. Such physicians shall be appointed from a list of physicians licensed to practice in the State of New Jersey, submitted to him by the State Medical Society.

2. a. A State Physician shall devote his entire time to the medical work of the Department, and shall engage in no other practice of Medicine; shall be adequately compensated, and shall not be removed from office except for just cause, after a hearing before the Commissioner of Labor and a representative of the State Medical Society.

b. Such State Physician shall at no time be employed by, nor accept nor participate in, any fee from any employer or his agent, nor in a like manner from any injured employee. He shall at no time solicit to treat any compensable case, nor shall he recommend any particular physician or surgeon, clinic or other institution or organization for the treatment of injury or disease, to either employer or employee. Any recommendations as to treatment of a case which he desires to submit shall be sent to the attending physician, and to the medical representative of the employer only, rendered in writing and recorded in the Department files on the case involved. He shall arbitrate disputes as to medical care between the attending physician and the medical consultant representative of the employer.

D. 1. The Board of Medical Referees shall be composed of the State Physicians and three of such Board shall be present at all hearings, exclusive of the State Physician the determination of whom is under advisement. The decision of this Board shall be by majority opinion of those sitting in the case.

2. The Board of Medical Referees shall render an annual report of all hearings and of other work accomplished during the year, to the Commissioner of Labor, which report shall be published and distributed to the members of the medical and legal professions and to all others concerned.

In conclusion the committee would earnestly recommend that the various items of its report be considered as basic principles for which we of the State Medical Society stand.

The committee suggests that there be continued activity on our part, to enact into the Compensation Law of New Jersey such amendments as will embody in the Law the principles proclaimed. It further suggests that, to accomplish this purpose, conferences be held between representatives of the State Medical Society, Employers, Casualty Underwriters, Legal Profession and Department of Labor, and that a Legislative Bill be drawn up which will be acceptable and equable to all parties concerned.

Respectfully submitted

J. IRVING FORT, *Chairman*
GEORGE W. FINKE.
V. EARL JOHNSON,
DAVID A. KRAKER,
JOHN F. MCGOVERN, JR.

REPORT OF THE ADVISORY COMMITTEE ON PHARMACEUTICAL PROBLEMS

By CHESTER I. ULMER, M.D., Gibbstown, N. J.

To the Welfare Committee:

This committee is a new one, functioning for the first time this year, and giving its first report. We have two primary objectives:

1. Inform and encourage the physicians to use and prescribe U. S. P., N. F., and N. J. F. preparations.

2. Preserve and improve the ethical and

cordial relationships between pharmacists and physicians.

For quite a long time it has been observed that many physicians have become indifferent about prescription writing, and have developed a tendency to prescribe certain pharmaceutical and proprietary products in preference to official preparations. After all, the doctor must share the responsibility with the druggist for having allowed the prescription department to become subordinated into a mere side issue of a drug store.

PAGE OF PRESCRIPTIONS IN THE JOURNAL

To help correct this tendency, and to assist in reviving the art of prescription writing, this committee is coöperating with a committee from the New Jersey Pharmaceutical Association, striving for improvement in the writing of prescriptions along ethical lines.

Our endeavor is to give to the doctors practical prescriptions which will take the place of certain well-known proprietary preparations. The Publication Committee is coöperating with our committee in this work, and we are able to present to the members of the Medical Society a set of six prescriptions appearing as an insert, bimonthly, in our Journal. These prescriptions are official formulas, and are similar in composition to many often-prescribed proprietary products. An earnest effort is being made by the Committee on Pharmaceutical Problems to make this new feature of The Journal of practical usefulness to every member of our Medical Society.

MEETINGS WITH PHARMACISTS

Joint meetings of physicians and pharmacists are being arranged to promote common interests and to maintain ethical and friendly relationships. One particularly noteworthy meeting was held in Paterson on December 10, 1936 (Jour., Jan. 1, 1937, p. 66). It was a joint meeting of the Paterson Pharmaceutical Association and the Passaic County Medical Society, and was held at the Alexander Hamilton Hotel. There were about 250 pharmacists and physicians present. The druggists were the hosts, and there was a fine, cordial spirit throughout the meeting. The joint subject for discussion was "Hazards and Hopes of the Pharmacal and Medical Professions". Professor A. F. Marquier of the Rutgers University, New Jersey College of Pharmacy, presented the subject as it referred to pharmacy; and the Chairman of this Committee as it referred to medicine.

It is hoped that other County Societies will arrange for similar joint meetings and sponsor them. Such meetings help in a great way to promote fellowship and better understanding between the two professions. Speakers for the medical side of the discussions are available from our committee, if desired.

The Committee on Pharmaceutical Problems met with the Committee on Professional Relations of the New Jersey Pharmaceutical Association on November 29th, 1936, and organized the *Joint Committee on Professional Relations.* Among the subjects discussed were the New Jersey Formulary, programs for pharmacists—physicians' meetings, standards for hospital pharmacies, and the pharmaceutical display at the State Medical Society meetings. It was decided that the Joint Committee will again have a pharmaceutical display of U. S. P., N. F., and N. J. F. preparations at the Annual Meeting of our State Society. Many of the preparations exhibited will be made according to the prescriptions which have appeared on our insert page in The Journal, and the physicians will have an opportunity to actually see and examine the products. One of the members of the pharmaceutical group will be at the booth to explain the formulas and answer questions. We would urge all the doctors to stop at the pharmaceutical display, and see first hand some of the work the committee is doing to promote the art of prescription writing and lessen the cost of medicines to patients.

The committee hopes to continue with its planned program. We believe that the bimonthly publication of the prescription page in The Journal is of real practical value to many of our members, and we would like to have it again approved.

Respectfully submitted,

Chester I. Ulmer, *Chairman*
Samuel Barbash
Merwin L. Hummel
Sigurd W. Johnsen
Alvin E. Kuhlmann

REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

By H. Roy Van Ness, M.D., Newark, N. J.

To the House of Delegates:

The Advisory Committee to the Woman's Auxiliary of The Medical Society of New Jersey has had a year of average activity, having met with a committee from the Auxiliary, and served whenever requested.

The main activities of the Auxiliary are carried out by the Public Relations and Program (Health Education) Committees of the Auxiliary, which sponsor reciprocity meetings, where representatives of lay groups are invited to hear talks on subjects of importance to health given by outstanding speakers, and introducing of five-minute health talks in lay organization meetings.

The Woman's Auxiliary throughout the State has obtained many contacts for members of the Speakers' Bureau. This work has great possibilities, and fills a very necessary need and desire of the public for information in health matters.

Members of the Auxiliary are constantly reminded that whenever wossible they should serve on the health committee of any club to which they may belong, and to establish a health committee in organizations where none exists.

The outstanding accomplishment of one County Auxiliary has been the formation of a health committee in one of the largest women's clubs in the State, where round-table conferences, directed by doctors, are to be established, five-minute health talks are to be given each month, and an article pertaining to health is to be published in their monthly paper.

The project of the Arts and Hobbies Committee is becoming a more important feature of the Auxiliary program. The addition to it of the Medical History of New Jersey has given an added interest to the work.

Your committee feels that The Medical Society of New Jersey, for the spread of its philosophy, has an efficient ally in the Woman's Auxiliary, and recommends that the committee, in addition to its advisory capacity, furnish the Auxiliary with a definite program, this program to be formulated by the committee after receiving suggestions from and coöperatnig with the Welfare Committee and its sub-committees.

We wish continued success to the Woman's Auxiliary, to which we are indebted for its untiring efforts in our behalf.

Respectfully submitted,

H. Roy Van Ness, *Chairman*
L. B. Beisler
Abraham E. Jaffin

REPORT OF STATE BOARD OF MEDICAL EXAMINERS OF NEW JERSEY

By James J. McGuire, M.D., F.A.C.P., Trenton, N. J.

LICENSES

During the period of March 15th, 1936, to March 15th, 1937, the State Board of Medical Examiners of New Jersey issued 392 certificates of license, as follows:

By examinations:		
Medicine and Surgery	169	
Osteopathic	65	
Chiropractic	5	
Chiropody	20	
	259	
By endorsement:		
Medicine and Surgery	133	
		392

There was a decrease of twenty-seven in the number of certificates of license issued during this period as compared with the preceding year.

Twenty-six of the medical licentiates were graduates of foreign medical colleges, but only eight were born in foreign countries, the other eighteen having been born in the United States. The following list shows that about 42 per cent of these licentiates were graduates of medical schools in Great Britain:

University of Edinburgh	3
University of London	4
University of Aberdeen	1
University of St. Andrews	2
University of Birmingham	1

University of Naples	3
University of Rome	1
University of Vienna	1
University of Berne	2
University of Lausanne	1
University of Geneva	2
University of Strassburg	1
University of Wurzburg	1
University of Frankford Am Main	1
Albert Ludwigs University	1
Syrian Protestant College	1

The following list shows the number of physicians and surgeons, and osteopaths, endorsed to other states, the number who died in the State of New Jersey, and the number of licenses revoked:

Physicians endorsed to other states	58
Osteopaths endorsed to other states	24
Deceased physicians	102
Deceased osteopaths	7
Medical licenses revoked or declared invalid	3
Osteopathic licenses revoked	1
Chiropractic licenses revoked	1
	196

From the above figures showing 392 licensed by examination and endorsement, and 196 who ceased to practice, it would be logical to conclude that the number of physicians, osteopaths, and chiropractors practicing in the State was increased by 196. This would, undoubtedly, be a false conclusion, as the Board has no way of ascertaining the number of New Jersey physicians, osteopaths, and chiropractors who are also licensed in other states as well as in New Jersey, and who leave this State to go into or resume practice in another state; nor of those who die in other states. If the law provided for an annual registration, the Board would have a record of the exact number of physicians, osteopaths, and chiropractors in the State and would know each year whether the number practicing was increasing or decreasing. The laws governing chiropody and midwifery do require an annual registration, and the records show that twelve less midwives and two more chiropodists registered this year than last year.

REVOCATIONS

The license of one physician and surgeon was revoked for conviction of the practice of criminal abortion, and two medical licenses became invalid and were automatically revoked through failure of the licensees to present evidence of citizenship. The licenses to practice osteopathy and chiropractic of one licentiate were revoked for the practice of criminal abortion.

ENFORCEMENT

Court Cases—Violation of Medical Practice Act:		
Convicted, pleaded guilty or settled	33	
Tried, decision reserved	4	
Lost, appeal taken	1	
Lost, no appeal	1	
Pending	18	
		57
Midwives and Chiropodists, Failure to Register:		
Tried or settled—Chiropodists	1	
Tried or settled—Midwives	5	
		6
Decisions of Higher Courts:		
Dismissed before trial, writ of certiorari allowed, judgment reversed and case remitted for trial	1	
Board of Regents of the State Board of Naturopathic Examiners of New Jersey, order dissolving corporation signed and filed with the Supreme Court	1	
		2
Hearings Before Board:		
Medical—License revoked	1	
Licenses invalid	2	
Osteopathic—License revoked	1	
Chiropractic—License revoked	1	
		5
		70

Type of Cases Investigated	No. Investigated	No. Visits
Druggists practicing medicine	40	266
Prescribing herbs, drugs and appliances	18	145
Medical doctors	4	10
Blood pressure diagnosis	6	32
Unlicensed chiropractors	9	71
Chiropractors exceeding license	3	38
Osteopaths, licensed and exceeding license	7	80
Chiropodists, unlicensed and exceeding license	3	24
Masseurs and massage treatments	2	14
Electro-therapy	8	45
Naturopaths	10	54
Midwives, unlicensed, not registered and exceeding license	5	12
Miscellaneous	44	79
Medical revocation	3	5
Colonic therapy	3	9
Unlicensed medical physicians	4	45
Osteopath, revocation	1	10
Chiropractor, revocation	1	10
Laboratories	1	3
Physiotherapists	3	20
Corporations	1	1
	176	973

Average number of visits per investigation 5.5

Respectfully submitted,

James J. McGuire, M.D.,
Secretary.

ADDENDA TO THE ANNUAL REPORT OF THE COMMITTEE ON MEDICAL DEFENSE

Continued from pages 236 and 237.

The Committee on Medical Defense wishes to add two explanatory communications to its annual report, which appears on pages 238 and 239.

Communication number one, November 23, 1936, from Dr. Christopher C. Beling to President Snedecor:

At a regular meeting held on Monday, November 23rd, 1936, the Committee on Medical Defense passed the following resolution:

"That the Committee on Medical Defense ask The Medical Society of New Jersey to arrange with the component County Medical Societies for the appointment of Medical Defense Committees, consisting of not more than three members, to act in coöperation with the Committee on Medical Defense of the State Society in all matters pertaining to the protection of the interests of members, against whom malpractice suits may be threatened or instituted."

In accordance with the action of the committee, I am submitting this resolution for your consideration and action.

In endeavoring to coöperate with the State Society and to keep down the premium rates, the Insurance Company looks to the committee for the investigation of claims for malpractice and the alleged attitude of certain physicians in promoting suits. In these and in many other matters, local committees can be of invaluable service by reason of a knowledge of local conditions and individual members. There are many other advantages to be gained from such coöperation.

If this plan meets with acceptance and committees are formed, our committee will be glad to confer with them and to arrange for Mr. William N. Heard, our official broker, who is not a representative of the company, to meet with them for the purpose of working out a mutual plan.

Such an arrangement should bind the members together more closely, provide a stronger defense, lessen the number of suits, and keep down or even reduce premium rates.

Communication number two, March 10, 1937, from Dr. Christopher C. Beling to the President, Secretary, and Chairman of the Medical Defense Committee of each component County Medical Society:

The Committee on Medical Defense, with the approval of the President of The Medical Society of New Jersey, presents the following for your information:

Recently the question has been asked regarding the propriety and advantage of having professional liability insurance through an official State broker. Assertions have been made that any local broker can write exactly the same policy with exactly the same advantages to the individual members, which they now have through the official broker.

Before answering this question, the committee considers it important that the component County Societies should be enlightened regarding the history, development, and present operation of the Medical Defense of the State Society.

Prior to 1921 the State Society, for the protection of its members, had a Medical Defense Act which provided inadequately for the defense of its members, and made no provision for indemnification for damages. Up to that time a member had to depend on his own judgment in selecting a company to protect him against malpractice claims, in addition to any defense that the Society offered him.

At its Annual Meeting in 1921 the Society abandoned its own medical defense act and adopted a plan of medical defense with insurance; and through its own broker, Faulhaber & Heard, Inc., of Newark, N. J., entered into a contract with the United States Fidelity and Guaranty Company under a group form of policy. As there was no information to guide the Insurance Company regarding claim experience, an arbitrary rate was agreed upon to be adjusted in accordance with the future developments of the risk and the volume of business done. The contract provided beneficial conditions not afforded by any other company, such as a broad form insuring clause, direct payment of damages instead of indemnification for losses incurred, consent of the insured for settlement of suits or claims, and other valuable features.

During the early years the members of the Society were slow in accepting the plan, and its development was tedious. As its benefits were pointed out by intensive education of individual members, largely through the direct personal efforts of our broker at his own expense, the number of insured members increased each year, until now practically 80 per cent of the members have availed themselves of protection under the contract.

During the entire period no monies of the State Society were expended by the Committe on Medical Defense for carrying on its work. An efficient organization has been developed for the benefit of the Medical Society through the services of the official broker, whose only compensation has been his regular brokerage fees paid by the company. He has rendered invaluable service to the committee which could not have been obtained without considerable expense. He maintains an efficient organization; keeps records of all contracts issued to members; informs the committee of any changes in policy conditions or rates; checks the Official List to safeguard members against the loss of their insuranee through some inadvertent oversight, error, or mistake; furnishes material for committee reports; bears advertising costs in the Journal and County Bulletins; and keeps the membership constantly reminded of the importance and necessity of protection against malpractice claims. He travels through the entire State to contact members so as to enlarge the group. The volume of business done has a direct bearing on the premium rate. Without the aid of an efficient organization no com-

mittee can hope to carry on the business of medical defense.

In view of these facts, the answer to the question propounded regarding the propriety and advantage of having malpractice insurance through an official State broker is evident.

It may be true that any local broker can write exactly the same policy with exactly the same advantages to the individual members; but what about the interests of the profession as represented by The Medical Society of New Jersey?

What kind of organized service will be rendered by individual agents? And who is to be held responsible to the committee and the Society without the proper official recognition, control, and coördination?

A study of the contracts offered by the few companies writing insurance in this field has not disclosed any advantages over those of our present contract. The committee has an open mind on this matter, and welcomes any constructive suggestions and proposals.

The County Societies are earnestly requested to coöperate with the State Society in its endeavor to maintain a high standard of medical defense. A reason for the appointment of county committees was that many problems of a more or less local character were being presented, which could be considered and disposed of satisfactorily only by the component societies.

In order to minimize risks and to maintain low rates, the Insurance Company has insisted on a careful and thorough investigation of the qualifications of applicants who desire to undertake specialized work, maintain beds in connection with their offices or homes, and to perform surgical operations outside of properly equipped hospitals. In this and many other matters the coöperation of the county committees will be needed. Our broker, therefore, will often have occasion to be in touch with the members of the county committees.

In conclusion, the committee is strongly of the opinion that it is necessary to maintain and strengthen the position of the State Society in the matter of medical defense and insurance against malpractice claims, and not to weaken the organization built up over a period of years by scattering its business loosely and promiscuously, and by connecting and confusing it with other forms of insurance, which are not of such vital interest to the profession. The success of this protection has been dependent upon the selection of a stable company, and a responsible agent who could negotiate for The Medical Society of New Jersey and safeguard the interests of its members.

REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES

President Snedecor has appointed Reference Committees in accordance with the By-Laws, Chapter VIII, Sections 14 and 15. The Annual Reports of the officers and committees are referred to these committees as indicated in the following list:

Reference Committee "A" to consider reports of:
The President
Addresses of the President and President-Elect
The Executive Officer
The Finance and Budget Committee
The Treasurer

Edward W. Sprague, Chairman ..... Newark
George M. Knowles ..... Hackensack
Inglis F. Frost ..... Morristown
H. Burton Walker ..... Vineland
Samuel Salasin ..... Atlantic City

Reference Committee "B" to consider reports of:
The Secretary
The Judicial Councilors
The Insurance Committee
The Advisory Committee to the Woman's Auxiliary
The Sub-Committee on Public Relations

Lancelot Ely, Chairman ..... Somerville
J. Howard Hornberger ..... Roebling
Reuben L. Sharp ..... Camden
Joseph W. Hurff ..... Newark
Harrison B. Wilson ..... Hackensack

Reference Committee "C" to consider reports of:
The Publication Committee
The Committee on Program and Arrangements
The Committee on Scientific Work
The Committee on Scientific Exhibits
The Welfare Committee
The Sub-Committee on Legislation

Edgar A. Ill, Chairman ..... Newark
Byron G. Sherman ..... Morristown
A. H. Coleman ..... Clinton
Henry Spence ..... Jersey City
Walter B. Mount ..... Montclair

Reference Committee "D" to consider reports of:
The Delegates to the A. M. A.
The Committee on Hospitals and Medical Education
The Board of Medical Examiners
The Committee on Honorary Membership
The Committee on Medical Defense

Leslie Myatt, Chairman ..... Bridgeton
Walter Rullman ..... Red Bank
William W. Pedrick ..... Glassboro
Runkle F. Hegeman ..... Somerville
Henry Haywood ..... New Brunswick

Reference Committee "E" to consider reports of:
The Sub-Committee on Public Health
and the Advisory Committees on:
Cancer Control
Child Health
Crippled Children

Maternal Welfare
Mental Hygiene
Tuberculosis
Venereal Disease Control

William H. Areson, Chairman..Upper Montclair
Elwood E. Downs .....Woodbury
Lorrimer B. Armstrong .....Westfield
C. Byron Blaisdell .....Long Branch
Charles H. Lyon .....Phillipsburg

Reference Committee "F" to consider reports of:
The Sub-Committee on Medical Practice
and the Advisory Committees on:
Contract Practice
Hospital Relationships
Medical Care to Indigents
Nursing and Nursing Education
Pharmaceutical Problems
Workmen's Compensation

Herschel Murphy, Chairman ..... Roselle
J. Lawrence Evans .....Woodcliff
Theodor Teimer .....Newark
Clarence W. Way .....Sea Isle City
David W. Green .....Salem

SPECIAL REFERENCE COMMITTEES

I. Constitution and By-Laws

Samuel Alexander, Chairman ...Park Ridge
Wayne W. Hall .....Paterson
Joseph M. Kuder .....Mount Holly
Hugh H. Tyndall .....Weehawken
Charles P. Bailey .....Lakewood

II. Resolutions and Memorials

Watson B. Morris, Chairman ...Springfield
A. Dunbar Hutchinson .....Trenton
Earl H. Snavely .....Newark
Frederic J. Quigley .....Union City
Jacob J. Mann .....Perth Amboy

III. Credentials

H. Roy Van Ness, Chairman .....Newark
J. Bennett Morrison .....Newark
Elias J. Marsh .....Paterson

IV. Miscellaneous Business

D. Leo Haggerty, Chairman .....Trenton
George F. Dandois .....Wildwood
Frederick H. Morrison .....Newton
William L. Williamson .....Bayonne
Wright MacMillan .....Passaic

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STATE SOCIETY ACTIVITIES

WELFARE COMMITTEE

A meeting of the Welfare Committee of The Medical Society of New Jersey was held on the afternoon of Sunday, April 4th, 1937, in Trenton, in the Stacy-Trent Hotel. The Chairman, Dr. Hilton S. Read, presided, and over forty members were present.

The principal object of the meeting was to give final consideration to the annual reports which will be submitted to the House of Delegates on April twenty-seventh. The method of action of the Welfare Committee is that each activity is in charge of an Advisory Committee; which reports to a Sub-Committee; which in turn makes its report and recommendations to the Welfare Committee, whose membership includes that of the subordinate committees. The final decision is therefore the collective opinion of a cross-section of representative physicians throughout the State.

THE MIDDLESEX COUNTY PLAN

In answer to a request from President Snedecor, Dr. J. J. Mann, Chairman of the Executive Committee of the Middlesex County Medical Society, gave a descriptive report on the method of giving service to the indigent, adopted by the County Society with the consent of the State Society. No clinics are held, except in the City of New Brunswick, but the indigent are treated in the offices of the doctors, who are paid fees which are allocated by the County Board of Freeholders.

Dr. Mann reported that practically all the doctors of the county are supporting the plan, and subscribe to the formula, "Every doctor's office a clinic". It opposes the principle, "Every clinic a doctor's competitor".

Dr. Mann outlined the agreements which the County Medical Society had made with the local governmental boards, and cited that with the city authorities of Perth Amboy, as follows:

A. The old relief set-up as originally devised in Middlesex County, and which later was adopted as the State Society Plan, was reëstablished.

B. In addition, this important paragraph was added: "Persons or families who may be eligible for medical care paid for by the Department *may be* those actually receiving other phases of relief, persons in the low-wage earning classification, and W. P. A. employees with large families and no additional or insufficient income according to the budget of the Department of Public Assistance."

C. Another important paragraph was added: "Medical care for cases of contagious diseases cared for in the home can be authorized through this department if no other means of care can be provided by city or county institutions."

Dr. Mann also outlined the methods of conducting venereal disease control, maternity cases, and baby keep-well stations. He said that all these projects are new, but have the support of the medical profession. A report on the actual experience of the Middlesex doctors may be expected in the Fall.

CANCER CONTROL

Dr. H. B. Orton, Chairman of the Advisory Committee on Cancer Control, gave an outline of a plan for a State-wide voluntary organization for cancer control, in order to meet the needs for more expensive equipment in hospitals, such as radium, and deep x-ray machines.

Dr. Stanley Nichols moved that Dr. Orton be asked to continue the development of his plans, and to present them to the State Society. This suggestion was adopted.

VENEREAL DISEASE CONTROL

Dr. C. H. deT. Shivers discussed the details which remain to be developed in setting up the means for venereal disease control, including the establishment of clinics, the appointment and pay of their directors, supplying drugs for treatment, and reporting cases.

Dr. Casselman discussed the means of control from the point of view of the State Department of Health.

FOOD AND DRUG ACT

Dr. Hilton S. Read described a visit which he and Dr. Burritt had made to Washington in regard to the Food and Drug Bill; and paid a high compliment to Senator A. Harry Moore and Representative Frank W. Towey, Jr., each of whom gave several hours of his time to a consideration of the points brought out by the doctors. Senator Moore had introduced a substitute for the Copeland Bill, but still that of Senator Copeland was enacted and is now before the House of Representatives for action, although amendments may be made in this body before a final vote is taken.

PUBLIC RELATIONS

Dr. J. H. Kler, Chairman of the Committee on Public Relations, discussed several projects in giving popular publicity to medical topics which the Society is developing, including pub-

licity of the proceedings of the Annual Meeting.

The question of the sterilization bill was also discussed. This bill is supported by the League of Women Voters, which is asking the support of The Medical Society of New Jersey. It was the opinion of the speakers that while the medical phase of the bill is simple, it is likely to be avoided because the legal, moral, and religious implications are so great that the medical phase is likely to be side-tracked.

The Welfare Committee voted to refer the question of supporting the sterilization campaign, to the House of Delegates.

MENTAL HYGIENE

Dr. J. S. Plant described a plan of "teaching clinics", to be conducted in the State hospitals as a means of teaching mental hygiene to family doctors; and said that the Department of Institutions and Agencies would cooperate in providing instructors and demonstrators for meetings to be held under the auspices of county societies. Dr. Plant gave cogent reasons why the instruction should be by the presentation of patients, rather than by textbook descriptions of mental diseases.

COST OF STATE SOCIETY ACTIVITIES

Dr. Herrman, President-Elect of The Medical Society of New Jersey, was asked to say a few words regarding the programs which the speakers had proposed. In reply, he alluded to the question of dues in order to provide the means of carrying out the suggestions which have been unanimously adopted by the members of the Welfare Committee. "If the object of the State Society", he said, "is merely to conduct an annual meeting, then the present dues are sufficient; but if the State Society is to lead public sentiment in medical affairs, it must have more funds. It is a question of *policy* for the House of Delegates to decide."

PARTICIPATION IN THE PUBLIC HEALTH PROGRAM

LETTER NUMBER 3—A STATEMENT TO THE PUBLIC

By Stanley Nichols, M.D., Chairman of the Sub-Committee on Public Health

This is the third letter in a series. The first was addressed to individual physicians, and appeared in The Journal of February, page 125. The second letter was addressed to County Medical Societies, and was printed in The Journal of March, page 199.

The dominant purpose of The Medical Society of New Jersey is better medical service, to be secured by two methods:

1. Instruction to its members in up-to-date scientific knowledge and practice.
2. The development of a better system of distributing the medical services which are available in a community.

Improved medical service is built upon two foundation stones:

1. The preservation of private medical practice by the family doctor.
2. The assumption of leadership by the Medical Society as the adviser of other organizations that deliver health services.

Definitely poorer medical service has invariably followed, both in this country and abroad, virtually all of the mechanistic, mass, or group attempts at the solution of this problem of better medical service.

Therefore, attempts in this country toward mass solutions of this problem of better medical service should be limited to such indigent and low-wage groups, among whom better medical service cannot be obtained for economic reasons. Even in these groups, some such solution as the past Emergency Relief plan should be attempted, as such plans accomplish a considerable degree of better medical service, through sacrifice of part of the fees on the part of the physician, and by the patient receiving individual medical service from the physician of his choice.

The field of preventive medicine and health supervision is a vital part of better medical service; and for its proper development all health groups should work toward making every physician's office in New Jersey a health center for the practice of preventive medicine.

It would be wise for any State, or county health groups wishing to undertake any field of health work, to enlist the advice and cooperation of the Public Health Committee of the State or County Medical Society. Official or non-official health agencies now engaged in any health field should now enlist the active coöperation of the Public Health Committee of the State or County Medical Society, and thus assure the actual integration of the Medical Profession in their efforts toward better medical service.

It is important that all persons interested in any phase of public welfare accept the fact that poorer, not better, medical service invari-

ably follows any and all efforts to cheapen this service by mass or group methods; and that they should assist the Medical Profession by educating the general public on three important points:

1. The general public does not now understand nor avail itself of one-tenth of the preventive medical practice now available in this State.
2. Better medical service and better health will cost more; but it will be, from every angle, well worth what it costs.
3. These increased costs and funds necessary for better medical service and better health can be easily provided, if all concerned will set about the task of educating the public to the fact that better medical service and better health is a necessity, and not a luxury; and that inasmuch as it is a necessity, one-tenth of the money now spent by the public on such luxuries as pleasure automobiling, cosmetics, tobacco, alcohol, radio, amusements, patent medicines, etc., will easily provide amply for all of the costs of better medical service and better health.

We respectfully suggest to our members and the county societies that this statement, or abstracts from its principles, as to better medical service shall be utilized by the members of the county societies by all possible means and methods of publicity, so as to inform all groups of the public, in each county, as to these important and essential facts regarding the field of better medical service, and the importance of the preservation of private practice as an integral factor in the accomplishment of better medical service, as the ideal of all concerned with the health of the people.

President Snedecor addressed the Medical Society of the County of Nassau, Long Island, on the evening of Tuesday, March 30th, on the subject "Medical Relief of the Indigent in New Jersey". Dr. Smith, President of the Society, replied that he was encouraged by Dr. Snedecor's description of the difficulties that New Jersey met in carrying out the plans with a high degree of success, for Nassau County is now facing the same difficulties.

The official program of the Annual Meeting, which opens on April 27, is already completed, over two weeks earlier than ever before. This will permit the printing of the program two weeks in advance of the Annual Meeting.

This early date of completing and printing the program will also enable the Executive Offices to introduce the innovation of mailing a copy to every member, almost as soon as The Journal is mailed. This service is possible because of the promptness of the officers and committeemen in making their reports promptly and in completing the arrangements at an early date.

Note the announcement on the first page of the department of "Seasonable Prescriptions". In booth 14 of the Scientific Exhibit there will be an exhibit of preparations made up according to the formulas which have appeared in The Journal. The Pharmaceutical Journal announces an increase in the patronage of the prescription departments of drug stores as a direct result of the prescription department of The Journal.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS SINCE JULY 1, 1936

DIPHTHERIA TOXOID

County	To Feb. 28	Month of March	Total to Mar. 31	Average per Month
Atlantic	255	128	383	42.5
Bergen	1067	109	1176	130.6
Burlington	219	586	805	89.4
Camden	464	46	510	56.4
Cape May	52	47	99	11.
Cumberland	242	19	261	29.
Essex	8780	627	9407	1045.2
Gloucester	161	0	161	17.8
Hudson	120	38	158	17.5
Hunterdon	106	0	106	11.7
Mercer	38	5	43	4.7
Middlesex	2052	371	2423	269.2
Monmouth	576	75	651	72.3
Morris	237	46	283	31.4
Ocean	233	68	301	33.4
Passaic	2906	603	3509	389.8
Salem	53	2	55	6.1
Somerset	1540	2	1542	171.3
Sussex	65	0	65	7.2
Union	841	67	908	100.8
Warren	358	160	518	57.4
Totals	**20365**	**2999**	**23364**	**2596.**

SMALLPOX VACCINE

County	To Feb. 28	Month of March	Total to Mar. 31	Average per Month
Atlantic	432	18	450	50.
Bergen	913	78	991	110.1
Burlington	230	0	230	25.5
Camden	459	115	574	63.7
Cape May	57	3	60	6.6
Cumberland	336	48	384	42.6
Essex	3776	308	4084	453.7
Gloucester	311	3	314	34.8
Hudson	73	6	79	8.7
Hunterdon	21	0	21	2.3
Mercer	73	4	77	8.5
Middlesex	624	9	633	73.6
Monmouth	1516	7	1523	169.2
Morris	799	83	882	98.
Ocean	138	119	257	28.5
Passaic	1945	73	2018	224.2
Salem	33	0	33	3.6
Somerset	40	0	40	4.4
Sussex	122	0	122	13.5
Union	1029	60	1089	121.
Warren	531	60	591	65.6
Totals	**13458**	**994**	**14452**	**1605.7**

TECHNICAL EXHIBITS AT THE ANNUAL MEETING

The Technical Exhibits at the Annual Meeting will be larger and more varied than ever before. The space assigned to them is abundant and easily accessible to all visitors. Mr. J. B. Tufts, manager and director of the Exhibits during the last two years, again has them in charge.

Reed and Carnrick, Jersey City, N. J., Booth 9, will display its products in Booth 9. This firm produced the first pepsin ever manufactured in this country, the first soluble tincture of the chloride of iron, the first elixirs, and the first malt product ever given to the medical profession, as well as the first endocrine products produced in the world. It was established way back in 1860, has always been in the forefront of endocrinal production. Its products are sold entirely through prescriptions by physicians.

Among the well-known prescription agents are the Estrogenic Hormone, Endomin, Entacarb, Nephritin, Protonuclein, Peptenzyme, Ovacoids, Testacoids, Ampacoids of Testicle, Prostate, and Ovary respectively, and various others which represent the internal secretions of the well-known glands.

Spicer and Company, Glendale, California, Booth 17, will be represented at The Medical Society of New Jersey convention in Hadden Hall, Atlantic City, April 26 to 29. It will feature *Edwenil,* a polyvalent antibacterial agent for use in the various endotoxic infections such as the respiratory diseases, boils, measles, etc.

Edwenil is a stable, colloidal, protein-free (by the Biuret test) solution for intramuscular injection, and is valuable in raising resistance to the endotoxic infections wthout causing detrimental reactions, either local or general. Full information will be available at Booth No. 17.

Spicer and Company, of Glendale, California, also have offices in Portland, Oregon; New York, Chicago and Dallas, Texas.

Vitamin Products Company, Milwaukee, Wisconsin, Booth 5, will display its products. A booklet called *Vitamin News* may be had by registering at their booth, which also entitles you to receive subsequent issues of Vitamin News, which are mailed monthly.

Information may also be had on their full line of *Vitamin Concentrates,* obtained from natural food sources, from A to G, inclusive, in tablet form.

H. J. Heinz Company, Booth 49, makers of the 57 Varieties, invites you to visit its new exhibit featuring strained foods, breakfast cereals, and olive oil.

Stop for a cold drink of *Heinz Tomato Juice,* and register for the third edition of the *Nutritional Chart.* The two previous editions were so enthusiastically received that it was thought advisable to make frequent revisions in order to keep abreast with the rapid advances in the field of nutrition.

The Liebel-Flarsheim Company of Cincinnati, Booths 24 and 25, will display its famous *Bovie electro-surgical units* and the *L-F Short and Ultra-Short Wave Generators.*

Features of the exhibit will be the popular Standard Model SW2-C Short Wave Generator with *Treatment Drum,* and demonstrations of office electro-surgical technics with the *Junior Bovie.*

The Walker-Gordon Laboratory Company, Plainsboro, N. J., Booth 41, cordially invites the Medical Profession to visit the booth, where *Certified, Vitamin D* and *Acidophilus milks* will be available.

H. G. Fischer & Company, Booth 28.—The latest *Fischer* model of Short Wave, X-Ray and other apparatus, to be exhibited and demonstrated by *H. G. Fischer & Company,* will interest physicians because of their many unique features of design and performance. The complete *Fischer* line includes *Shockproof X-Ray* apparatus, short wave units, combination cabinets, galvanic generators, ultra-violet and infra-red lamps; tissue-cutting and other units, accessories and supplies. *Fischer* apparatus has been recognized as highest quality for more than twenty-five years. Physicians attending the convention are invited to ask for demonstrations of models in which they are interested or to consult with *Fischer* representatives regarding technics made available by *Fischer* apparatus.

J. B. Lippincott Company, Booth 36, will show some unusual new books, including Pfaundler & Schlossmann *"Diseases of Children"*; Peham & Amreich *"Operative Gynecology"*; Kirschner & Ravdin *"Operative Surgery"*; Means' *"Thyroid"*; Emerson *"Textbook of Medicine"*; McBride *"Disability Evaluation"*; Herrmann *"Passive Vascular Exercises"*; Barker *"Treatment of the Commoner Diseases"*; Emerson *"The Nervous Patient"*; Barborka *"Treatment by Diet"*; Goldthwait *"Body Mechanics"*; Sr. Gabriel *"Through the Patient's Eyes"*; Moore *"Principles of Ethics"*.

And the new editions just issued of these well-known texts and reference books: Eisendrath & Rolnick *"Urology"*; Anspach *"Gynecology"*; Davis & Muller *"Applied Anatomy"*; Thorek *"Surgical Errors and Safeguards"*; Rehberger *"Quick Reference Book of Medicine and Surgery"*; *International Clinics;* and *Annals of Surgery.*

All these books are unusually and beautifully illustrated, with the exception of Barker, and must be seen to be appreciated. You will be welcome at the booth and will not be importuned to buy.

Burroughs Wellcome & Co. (U. S. A.), Inc., Booth 8, presents a wide range of professional

preparations representing recent advances in scientific research in pharmacology, chemistry, vitamins, and dietary adjuncts.

The Cameron Heartometer Company, Booth No. 35, is showing the *Cameron Heartometer,* an outstanding achievement in cardiac diagnosis. It records graphically, diastolic and systolic blood pressure, number of pulse per minute, and the force and form of the heart impulse.

The Cameron Surgical Specialty Company, Booths Nos. 1 & 2, is showing the latest developments in electrically lighted lamps and instruments for surgery and diagnosis.

The new and inexpensive model of *Cameron Cauterodyne* (Radio Frequency) which provides safe and effective cutting, coagulating, dessicating and fulgurating with a quick-healing bloodless field for all phases of surgery is also being shown.

In **The Coward Booth No. 48** you will find a display of shoes showing the work of seventy years of effort to build footwear suitable for all types of feet. Be sure to investigate the new type of construction for women's shoes which gives flexibility along with rigidity. Each feature is arranged where it is most needed for support and protection. Years of experience has shown to Coward the need for eighty-five different lasts, for as many different types of feet in men, women and children. Constant study and application in fitting this equipment enables Coward to fill all prescriptions with accuracy and effectiveness.

Gerber Products Company, Booth 31, will display *Gerber's Strained Foods* for infant feeding and special diets.

Gerber's have two types of literature, some for distribution to patients, and some for professional use only. Samples of the foods and the literature for examination will be sent to registrants at the booth.

The Denver Chemical Mfg. Co., Booth 32, will show its well-known product, *Antiphlogistine,* now in its forty-third year, and employed by physicians in all parts of the world in the treatment of inflammatory and congestive conditions. There is only one way in which an ethical product can attain this distinction, and that is through merit. Physicians are invited to visit the exhibit and register for a package of *Antiphlogistine.*

Middlewest Instrument Company, Chicago Illinois, Booth No. 14.—Be sure to stop at Booth 14 when your are visiting the technical exhibits and get a few very interesting and educational facts on the *New Jones Motor Basal unit.*

It is Council accepted, guaranteed for life, contains no water, and embodies many exclusive features which will interest you.

Mead Johnson and Company, Booth 34.—A feature of the Mead Johnson exhibit will be a display of the *Percomorph* group of products; namely, *Mead's Oleum Percomorphum,* 50 per cent in liquid and in capsule form, and *Mead's Cod-Liver Oil Fortified with Percomorph Liver Oil.*

C. V. Mosby Company, Booth 23, will exhibit its complete line of medical publications in Booth No. 23. Among the newer items will be the two-volume work by Horsley and Bigger on *"Operative Surgery";* Titus, *"Management of Difficult Obstetric Cases";* Meakins, *"Practice of Medicine";* Sadler, *"Theory and Practice of Psychiatry";* and Hollender, *"Physical Therapeutic Methods in Otolaryngology".* Doctors attending the convention are cordially invited to look over these and all other Mosby publications.

Philip Morris & Co., Ltd., Inc., Booth 6, will demonstrate the method by which it was found that *Philip Morris cigarettes,* in which diethylene glycol is used as the hygroscopic agent, are less irritating than ordinary cigarettes in which glycerine is employed.

The Schering Corporation, Booths 3 & 4, will issue the latest information of endocrine therapy, and will explain the use of scientific follicular hormone preparations, *Progynon-DH tablets* and *Progynon-B* in a solution of oil, in menopausal disorders, amenorrheas, gonorrheal vaginitis, nausea and vomiting of pregnancy; the use of *Proluton,* synthetic *corpus luteum* hormone, in cases of threatened and habitual abortion. Reports on the new synthetic male sex hormone, *Oreton,* will also be available. Interesting reprints may be had for the asking.

Physicians Underwriting Agency, Newark, N. J., is an entirely new set-up on automobile insurance to cover the developing needs of the doctors of the Medical Society. Inquire at **Booth 22** at the Convention.

The Wander Company announces that for several years *Ovaltine* has been fortified with vitamin D to the extent of 154 international units per ounce by the Steenbock Irradiation Process under license of the Wisconsin Alumni Research Foundation. Three heaping teaspoons of *Ovaltine* in a glass of milk used three times daily provides 275 international units of vitamin D, as well as practically the full daily requirement of the important minerals, calcium and phosphorus in proper ratio.

At **Booth 47,** that of the **United States Fidelity & Guaranty Company,** all information can be obtained about professional liability and all other forms of insurance required by the society members.

Any physicians who have had an opportunity to test the service of this great company can appreciate the value of secure and dependable insurance and its unqualified ability to serve them.

The Arlington Chemical Company, Yonkers, N. Y., in Booth 21, will feature its protein and pollen extracts for diagnosis and desensitization of allergic conditions, especially the one dollar diagnostic pollen outfits, and the $25.00 and $35.00 protein outfits. Its experts at its booth will be pleased to discuss any allergic problems.

The company's old pharmaceutical favorites will, of course, be exhibited again.

The Picker X-Ray Company, Booth 38.—The *Waite Shockpr f Fluoroscope* to be shown here combines utility and complete safety, with a surprising economy in cost.

There will also be on display the new *Waite Shockproof Mobile Unit,* which is being installed in many of the leading institutions throughout the United States.

Horlick's Malted Milk Corporation in Booth No. 33, will explain the special advantages of *Horlick's Malted Milk* as a nutritious, easily digested food-drink, often acceptable when no other food can be tolerated. Its special value will be pointed out—

1. For infant feeding;
2. For growing children;
3. For nursing mothers;
4. For the undernourished;
5. For the sick, especially in fever and ulcer diets.
6. For the convalescent;
7. In sleeplessness.

The A. C. Barnes Company of New Brunswick, N. J., have for thirty-five years been the sole makers of *Argyrol* and *Ovoferrin.* Physicians may be interested in the comparatively new *Argyrol Tablets.* These not only insure accuracy, purity and genuineness, but also save time, because a fresh, potent solution is thus made available at a moment's notice in the doctor's office, in the operating room and at the bedside.

Argyrol is the original mild silver protein, the prototype of many imitative preparations. Recent research shows that there is a great variation of products so classified under the United States Pharmacopoeia. These differences show that Argyrol is superior in colloidal dispersion, Brownian movement, silver and hydrogen ion concentration control, quality of protein, and in germicidal standards.

The Mennen Company, Newark, N. J., will exhibit their two famous baby products—*Antiseptic Oil* and *Antiseptic Borated Powder.* Be sure to register at their exhibit nad receive samples of these products, as well as the opportunity to participate in the lucky number drawing for two *De Luxe Fitted Leather Travel Kits.*

In **Booth No. 13, The Radium Emanation Corporation** will exhibit a wide variety of instruments and applicators used in modern radium therapy, including permanent and removable leak-proof Radon seeds. The advantages of these seeds will be demonstrated by magnified sections showing their construction in detail.

The Kalak Water Co. of New York, Inc., will occupy Booth No. , and invites physicians to visit the booth and learn how delicious and refreshing Kalak is when properly served.

What is Kalak Water?

Kalak Water is a solution of salts, the amounts of which per unit volume resemble the constitution of blood-serum.

The earthy substances, calcium, magnesium, and sodium, occur typically in blood as the bicarbonates. No other water available to the physician has this composition—Kalak is made from distilled water, into which each of these ingredients has been dissolved on charging with carbon dioxide at definite pressure. There is present in blood some potassium and some phosphate, the proportion of these various ingredients in Kalak approximates the quantitative needs of the body. For instance, the phosphorous-calcium ratio is practically that which is normal for the body, a slight excess of calcium being used to overcome that lost in the alimentary tract.

Squibb Exhibit in Booth No. 15.—The complete line of Squibb *Vitamin, Glandular, Arsenical,* and *Biological* products and specialties, as well as a number of interesting new items, will be featured, including *protamine zinc insulin,* a new chemotherapeutic agent for treatment of hemolytic streptococcic infections, and a new urinary antiseptic.

Well-informed Squibb representatives will be on hand to welcome you and to furnish any information desired on the products displayed.

The National Casualty Co.—The group disability policy of the members of The Medical Society of New Jersey is now in its eleventh year. The continued satisfaction of the doctors is exemplified in their many testimonial letters on file with the Insurance Committee. The underwriters are the National Casualty Company, an "A Plus" ranking company; and the official accident and health insurance brokers for the Society are E. & W. Blanksteen of Jersey City, with Mr. W. Blanksteen in personal charge at this exhibit.

Professional Electro-Medical Co.—At **Booth No. 16** will be found a complete display of *Lepel equipment,* including *Short and Ultra Short Wave apparatus* embracing circuits for ultraviolet and surgery from the same units. Prices range from $325.00 up. There are also *Diathermy Machines, Ultraviolet Lamps* and *Portable X-ray units* displayed by the distributors for New Jersey, Professional Electro-Medical Company, 1060 Broad Street, Newark, N. J.

DR. A. HAINES LIPPINCOTT

MEMORIAL ADOPTED AT A SPECIAL MEETING OF THE CAMDEN COUNTY MEDICAL SOCIETY, MARCH 14, 1937



Dr. A. Haines Lippincott, President of The Medical Society of New Jersey, 1932.
July 12, 1867—March 10, 1937.

The Camden County Medical Society is assembled here in special meeting to pay fitting tribute to a departed member. Through the years, one and then another have been called from life's endless toil and endeavor to their eternal rest. Always at these special meetings among those who were present and who thought it worth while to pause in life's busy swirl to pay respect to a fellow-physician, Dr. A. Haines Lippincott would be found. It seems, therefore, entirely fitting that this goodly representation of the Camden County Medical Society is gathered together to render silent homage to so real a friend. This resolution is to be a part of the archives of our Society and also an expression to Mrs. Lippincott of our profound sorrow at the sudden termination of our happy associations with Dr. Lippincott.

Born on July 12th, 1867, in Evesham Township, Burlington County, New Jersey, A. Haines Lippincott grew to young manhood. Educated in the public and private schools in Medford, New Jersey, and at the Philadelphia College of Pharmacy, he entered the Jefferson Medical College to study his chosen profession and received the degree of Doctor of Medicine in 1892. Dr. Lippincott served this institution in the Out-Patient Department for fifteen years. After a post-graduate course in urology at the New York Post-Graduate Hospital, he was appointed in 1906 as Urologist to the Cooper Hospital, Camden, New Jersey, and as the head of this department he continued until his death on March 10th, 1937.

For a number of years Dr. Lippincott was Police and Fire Surgeon of Camden, and also served as a Coroner of Camden County. During the epidemic of influenza in 1918 an emergency ward was established at the Cooper Hospital, and Dr. Lippincott was placed in full charge. Among the many offices which were held by Dr. Lippincott were the following: Past President of the Camden City Medical Society, Past President of the Camden County Medical Society, Past President of The Medical Society of New Jersey, Past President of the Philadelphia Urological Society and Vice-President of the Staff of the Cooper Hospital. For years Dr. Lippincott served on the Welfare Committee of the State Society, and was Chairman of the Emergency Relief Committee of our County Society. He was a Fellow of the American College of Surgeons, a Trustee of Jeanes Hospital, and was on the consulting staff of the Newcomb Hospital at Vineland, and the Camden County General Hospital. He was Past Exalted Ruler of the Beneficial Protective Order of Elks, an organization which has done so much toward the rehabilitation of the crippled children in our community.

Throughout the years of his medical activities, Dr. Lippincott set a high standard of medical ethics for himself, and to this standard he rigidly adhered. He was no respecter of persons. He treated rich and poor alike, and there will be many who in the years will rise and call him blessed.

Dr. A. Haines Lippincott had those personal qualities so essential in the real physician. Honesty, sincerity, and loyalty were of his inmost fiber. Kindliness, friendliness, and sympathetic understanding were his outstanding attributes. His never-failing sense of humor, and the mischievous twinkle in his eyes as he engaged one in conversation made his mere acquaintance a privilege; and to have had him for a friend was indeed high honor.

Such a life as exemplified in Dr. Lippincott does not abruptly cease. His life will linger long in our memories to enrich our lives; and the soul of him will live on and on to hallow and to bless. We will continue to talk of him. He will be the invisible guest at our meetings and in our groups, and we wish for his bereaved wife, Mrs. Lippincott, a future filled with happy memories of the years lived together. We can the better appreciate Mrs. Lippincott's bereavement as we mourn our loss of so real a friend.

Joseph E. Roberts
P. M. Mecray
T. B. Lee
T. M. Kain

DR. EDWARD H. SALMON

March 28, 1879—February 28, 1937

Dr. Edward H. Salmon, of 669 Bergen Avenue, Jersey City, died Sunday, February 28th, 1937, at the Jersey City Medical Center. Death was due to a malignancy of the neck.

Dr. Salmon was born March 28th, 1875, in Hartford, Conn. He was educated at St. Peter's Parochial School, St. Peter's Preparatory and St. Peter's College, Jersey City. He received his medical education at the University of Maryland Medical School, graduating in 1907, and served his internship at St. Francis Hospital, Jersey City.

Dr. Salmon had been affiliated with the Jersey City Health Bureau since 1911. He succeeded Dr. Joseph Craven, who died in 1924, as Chief of the Communicable Disease Division of the Jersey City Board of Health. Last March the employees of the Board of Health tendered him a dinner on the occasion of his twenty-five years' affiliation with that organization.

Dr. Salmon was the first local doctor to use serums in the treatment of infantile paralysis. He had previously used serums for other ailments, pioneering in the work. At the time of the influenza during and after the war, and during the smallpox epidemic of 1926, Dr. Salmon established clinics and did very effective work. He was given credit for entirely stamping out the latter disease.

About ten years ago, Dr. Salmon fought a hard battle for the establishment of a venereal disease clinic for adults. Four years ago he was responsible for the establishment of a children's clinic for congenital venereal disease. At the children's venereal clinic, Dr. Salmon had as many as 200 children under treatment. He also established evening clinics for parents of these children. He had a clinic, too, in the Margaret Hague Maternity Hospital for pre-natal cases of venereal disease.

Fifteen years ago Dr. Salmon was instrumental in having all food handlers examined by physicians, and caused them to carry cards of good health.

Dr. Salmon was a member of the Hudson County Medical Society; Medical Society of New Jersey; American Medical Association; Knights of Columbus; Seventh Ward Democratic Club; Jersey City Lodge of Elks, Number 211; and the Holy Name Society of St. Aedan's R. C. Church.

Dr. Salmon is survived by his wife, Teresa, nee Kennedy; three daughters, Julia, Patricia and Joan; and two sons, Leo and Joseph.

DR. CHARLES F. HALSTED

Dr. Charles F. Halsted, of Somerville, died on March 8th, 1937. He was born in Morristown, N. J., on March 31st, 1868. He graduated from the College of Physicians and Surgeons in 1890, and also from the New York University Medical School in the same year. He served his interneship in the All Souls Hospital in Morristown, and practiced in High Bridge for twelve years. He then removed to Somerville where he practiced during the rest of his life, serving on the Staff of the Somerset Hospital. He was a member of the Knights of Pythias and the St. John's Episcopal Church.

The Somerset County Medical Society adopted the following memorial resolutions:

"The Somerset County Medical Society loses a valuable member by the death of Dr. Charles F. Halsted, on March 8th, 1937.

"Dr. Halsted was a faithful family practitioner, ready and willing to render his services whenever called upon, a citizen with deep interest in civic affairs, a ready friend, and a gentleman in courtesy to his fellow practitioners.

"Wishing to record its loss of a co-member and to express sympathy, be it resolved,

"That a copy of these resolutions be sent to the family, and also recorded on the minutes of the Somerset County Medical Society, the State Medical Society, and the public press.

"The Committee—

"LANCELOT ELY
"R. F. HEGEMAN
"L. C. FRITTS."

LIST OF PHYSICIANS DYING IN NEW JERSEY IN FEBRUARY

Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Herman L. Fuerstman	52	Feb. 12, 1937	Newark	Same	Coronary thrombosis.
John F. Hagerty	67	Feb. 1, 1937	Newark	Same	Lobar pneumonia.
Walter S. Reed	72	Feb. 28, 1937	Monmouth Beach	Long Branch	Carcinoma of prostate.
Edward Salmon	62	Feb. 28, 1937	Jersey City	Same	Epithelioma.

CONTACTS AND COMMENTS

THE MEDICAL REPORT OF THE AMERICAN FOUNDATION STUDIES IN GOVERNMENT

The Sunday morning papers of April 4th contain the announcement of the publication of the American Foundation Studies in Government on the subject "American Medicine", in two volumes. The books summarize the answers to a questionnaire sent to several thousand physicians throughout the United States, as described in this Journal of January, 1936, pages 35-38, and April, 1936, page 220. The answers were discussed at length in editorials in the New York Times and the New York Herald Tribune of April 4th; and the Times Magazine also printed a two-page article on the subject by Esther Everett Lape, member in charge of the questionnaire. The April issue of the Atlantic Monthly, page 463, also contains a leading article on the subject by Miss Lape.

On April 2 the Executive Offices also received an advance notice of the forthcoming publication, consisting of ten galleys of a summary of the study which would fill about ten pages of this Journal. This was the twentieth anniversary of the assembling of the Congress which passed the resolution declaring "War to end war" on the Central Powers of Europe,—an event to which the Sunday Magazine of the New York Times gave about the same amount of space that it gave to the study of the present needs in medical service.

During the two years preceding the declaration of war, Dr. Leonard Wood had conducted a campaign for preparedness and prevention which resembled that which The Medical Society of New Jersey has actively conducted on medical preparedness during the past two years among its own members, and which it is now extending to all the citizens of the State. The Welfare Committee, with its four sub-committees, and thirteen advisory committees, has been entirely constructive in its studies and suggestions, which are summarized in its "Handbook of Preventive Procedures".

The Medical Profession of New Jersey awaits with keen interest the summary of the diagnosis made by the American Foundation of Government, and hopes that the opinions of the two thousand physicians who replied to the questionnaire will confirm the soundness of the steps already taken by The Medical Society of New Jersey, whose characteristic has been constructive *evolution* rather than destructive *revolution*.

The Medical Society of New Jersey gratefully acknowledges the gift of bound volumes of The Journal for the years 1921, 1922, and 1923 by the Academy of Medicine of Northern New Jersey. This completes our files of records and Journals from the day of the founding of the Society on July 23, 1766, to the present day. The files are consulted daily, and are essential in carrying on the activities of the Society.

The Executive Staff is now settled in its new offices in room 831 of the office building of the Broad Street Bank, at 143 East State Street, two doors east of its former location. The telephone number remains the same—Trenton 9330. The staff now has space for storing the rapidly increasing files, and for mimeographing, and for carrying on all the varied phases of work of the Society.

The services of the Executive Offices are at the disposal of the county societies; and it is gratifying to note that the services rendered to the component societies is constantly increasing in amount and importance.

A most excellent summary of the objectives and methods of the United States Public Health Service in Venereal Disease Control is contained in the Readers' Digest of April, page 21, by Dr. Thomas Parran, Surgeon General. Read this summary in connection with Dr. Shivers' report of the work of the Advisory Committee on Venereal Disease Control on page 264 of this issue of The Journal. A work well begun is already half done.

The Bulletins of the Medical Societies of Morris and Middlesex Counties carry appreciations of the meeting of the Welfare Committee on February 28. That of Morris County Society says:

It certainly pays to read your State Journal. We earnestly request that you read your March Journal especially about the meeting of the Welfare Committee held on February 28th at Trenton, and not only taste this subject matter, but actually digest the news under all these topics:

1. Report of Committee on Nursing and Nursing Education.
2. Report of Reference Committee on Wiley Act Amendment.
3. Dr. Levine's paternity blood test.
4. Legislation.

All of this information is extremely important to you as a practicing physician in this State, and we cannot urge you too strongly to know about these topics. *Read your March Journal.*

That of Middlesex County describes the meeting as follows:

On February 28th there was a meeting of the Welfare Committee of the State Society; Chairman Hilton S. Read presided. The meeting was held in Trenton, and attended by Drs. Rowland, Mann, Kler, Avery, and Sandella, from our county. It was a new and stimulating experience to see such an important cog in the State Society in action. I believe that every one would profit greatly and come to a real appreciation of the work that the parent organization is accomplishing in the behalf of the rank and file of the profession. It was a pleasure to hear these men give committee reports that patently indicated the tremendous amount of time and work involved in the accomplishment. What wonders could be achieved if this drive and efficiency went down to the smallest county committee.

The April Bulletin of the Passaic County Society devotes two pages to the organization of its Speakers' Bureau, and lists fifteen members as speakers on the public health hour, maternal health, child welfare, regular adult supervision, cancer control, and other subjects discussed in the Handbook of Preventive Procedures, to which the article makes complimentary reference.

The April Bulletin of the Camden County Medical Society prints the following appreciation of The Journal:

The March issue of the State Journal and its supplement is a great credit to the editors and Committee Chairmen. It reflects the "up and going" attitude of organized medicine. May it receive proper appreciation among the membership!

It has been the constant aim of the Publication Committee that The Journal shall be of practical service to the county societies and their members. If The Journal has progressed in those aims, it is because the local societies are supplying it with news of activities which reflect their own great progress.

A Social Hygiene Conference of Monmouth County was held in Asbury Park on April first, under the county-wide Committee on Venereal Disease Control, and was attended by Dr. Wilkes. Sections were devoted to the following subjects:

The doctor's rôle in a campaign against syphilis.

An institute for nurses, teachers, and committee members.

A section for health officers.

A panel of three-minute speakers on various phases of the work.

The program lists twenty-four Monmouth County organizations taking part in the conference.

The American Association on Mental Deficiency will hold its sixty-first annual convention in Haddon Hall, Atlantic City, on May 5-8, 1937. Ten speakers from New Jersey are listed, consisting of two M.D.'s,—Dr. Dan S. Renner, of Skillman, and Dr. E. A. Doll, of Vineland; five Doctors of Philosophy; and three women teachers and physical trainers.

The non-medical workers in mental hygiene are as essential as are nurses and technicians in the field of medicine and surgery.

The Ohio State Medical Association has issued an eighteen-page folder, listing the activities of thirty-one states in coöperation with the Federal Security Act. The study was based on information received from the Secretaries of the Medical Societies of thirty-one states.

Information such as this would be a valuable feature of the Journal of the American Medical Association.

Somerset and Bergen Counties each have issued a folder describing a post-graduate course of five lectures in preventive pediatrics to be given during the months of April and May by Drs. Charles Hendee Smith, Leonard T. Davison, Adolphe De Sanctis, Samuel Karlitz, and Bela Schick. These lecturers are skilled in presenting their subjects in a simple, practical way which will be appreciated by all members of the societies.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

APRIL

6	Camden	13	Cumberland
6	Cape May	14	Mercer
6	Hudson	14	Ocean
8	Burlington	14	Union
8	Essex	15	Gloucester
8	Passaic	20	Warren
8	Somerset	21	Middlesex
9	Atlantic	27	Hunterdon
9	Salem	28	Monmouth
13	Bergen		

MAY

4	Camden	14	Atlantic
4	Hudson	19	Middlesex
11	Bergen	20	Gloucester
12	Mercer	26	Monmouth
12	Ocean		Salem (Social Meeting)
13	Burlington		Sussex (At call of President)
13	Essex		
13	Passaic		

ATLANTIC COUNTY

E. H. Nickman, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held March 12th, 1937, at the Ambassador Hotel, with President John S. Irvin presiding, and fifty-five members and guests present.

MEMORIALS

Dr. Carrington make a motion, which was passed, that a committee be appointed to memorialize Dr. E. H. Harvey.

Dr. C. H. deT. Shivers read a notice of the death of Dr. A. H. Lippincott, of Camden, N. J., and a motion was passed that Dr. Shivers should officially represent this society at the funeral.

ANNUAL MEETING, STATE SOCIETY

Dr. C. B. Kaighn brought to the attention of those present that the State Convention would be held soon and asked that the society give its support to the fine programs which have been arranged.

LETTER TO LEGISLATOR

Dr. Barbash, in response to a request from the State Society, has written to our Legislator, Edison Hedges, with regard to legislation of importance to the profession. Mr. Hedges replied to Dr. Barbash, stating that no other physician had so written him, but that he would be glad to work with the physicians.

Dr. Irvin stated that we do not pay sufficient attention to the requests of the State Society, and that there should be more coöperation with it.

A letter from the Crippled Children's Commission stated that all children, after special care or hospitalization, should be sent back to their family physician for further care. Dr. Quinn stated that there was now a visiting teacher for children to be taught at home when unable to attend school, and that there is no tuition charge. He requested the members to secure this service for any such patients as they may have.

MEDICAL DEFENSE

A letter was read from the Medical Defense Committee of the State Society explaining the group form of insurance for physicians under the plan of the Fidelity Mutual Insurance Co. Dr. Allman stated that he thought that all insurance should be placed locally since our own brokers know us and can take better care of our insurance needs, because they have a personal interest in us, whereas to an insurance company of North Jersey we would just be another premium source.

Dr. Irvin stated that the society had no committee under this heading; Dr. Davidson stated that the Board of Censors had always taken care of any emergency. Dr. Quinn stated that he felt that the Board of Censors were the ones who should take care of this, because they are the best informed group we could obtain since they are all Past-Presidents of the society.

A motion was passed that the Board of Censors should function as the Medical Defense Committee of this society.

NEW MEMBERS

Applications for membership were received from Drs. Harris, Bedell, and Marshall and all were refered to the Boad of Censors.

Dr. Richard C. Bew was unanimously elected to membership.

BABY KEEP-WELL STATION

Dr. V. E. Johnson, reporting for the Public Health Committee, stated that no appointment to the Baby Keep-Well Station at Hammonton had been made because some of the practitioners were not known. When it was brought out that Dr. Frazier Elliott was the only member of this society in Hammantown, it was decided that he should have the appointment. It was suggested that this action might act as an incentive to the others to become members of their county society.

POPULAR MEDICAL LECTURES

Dr. Johnson also read a request for members to prepare papers for lay gatherings such as Parent-Teacher Associations, Service Clubs, Women's Clubs, etc., or for presentation in other parts of the State. Subjects were suggested and an outline given. One point to be stressed in all papers is the progress made in medicine.

At a meeting of the officers of all the societies of medical derivation in the county it was decided to send a letter to all lay organizations informing them that speakers are available.

COMPENSATION INSURANCE

Dr. Johnson also reported that the action of the Advisory Committee on Compensation Insurance had been made to the State Welfare Committee.

LEGISLATIVE CONTACTS

Dr. D. B. Allman reported for the Legislation Committee that there were a number of bills coming up at this session of importance to the medical profession, and stated that our legislators had been properly informed and would vote favorably to the society's interests.

VENEREAL DISEASE CONTROL

Dr. C. H. deT. Shivers made a report of the recommendations to the Venereal Disease Control Committee which included those members of the present clinic staff. The Board provides that only in the event of vacancies can additional recommendations be made. This caused considerable discussion, as there were other applications on file for work in this clinic. Dr. Salasin stated that additional money would be forthcoming from the Board only in the event that the City of Atlantic City would match it with a like amount.

After much discussion, a motion was passed that all applicants for work in this clinic be recommended by the society.

INCORPORATING THE COUNTY SOCIETY

Dr. W. J. Carrington reported on the advisability of incorporating the society, and a motion was passed that this step should be carried out.

As the program for this meeting was to have been a discussion of the report of the Medical Economics Committee and the hour had become so late, a motion was passed that a special meeting be held March 19th for this purpose as it contained too much of importance to be discussed hurriedly.

Adjournment.

BERGEN COUNTY

LeRoy W. Black, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held at the Englewood Hospital on Tuesday, March 9th.

VENEREAL DISEASE CONTROL

The minutes of the Executive Committee were read and approved. Special attention was called to the resolutions proposed by the Venereal Disease Committee, proposing:

1. That standard drugs be made available for use in the treatment of all syphilis patients.
2. That a trained syphilologist be made available to Bergen County physicians to explain venereal disease standard practices.
3. That a marriage law be approved in spirit requiring contracting parties to be free from active syphilis.
4. That another trained venereal disease social worker be appointed for the eastern part of Bergen County.

These resolutions were unanimously approved.

COMMUNICATIONS

1. An announcement of the annual Post-Graduate Institute of the Philadelphia County Medical Society April 12th to 16th.
2. A letter from Mrs. H. Trautmann, Secretary and Treasurer of the Wallington Board of Health, asking that all communicable diseases be reported within twenty-four hours after the diagnosis.
3. A letter from Dr. LeRoy A. Wilkes announcing the removal of the offices of The Medical Society of New Jersey to 143 East State Street, Trenton.
4. A letter from Dr. Wilkes announcing the cooperation of the Crippled Children's Commission of New Jersey.

ANNOUNCEMENTS

Dr. G. Barton Barlow announced that the post-graduate course on "Glands of Internal Secretion" was being held on Thursday afternoon of each week, and that a large number were taking the course.

Dr. Lyman Burnham, field worker for the Maternal Welfare Committee, stated that he had many requests for nurses, but very few for consultation.

Dr. S. T. Snedecor spoke upon the activities of The Medical Society of New Jersey. In discussing the appropriations of social security funds for venereal disease, he stated that practically all of the venereal disease work was done in clinics and that poorly done. In response to his request as to how many physicians were willing to treat syphilis, almost every physician present indicated his willingness.

He announced that The Medical Society of New Jersey had received full coöperation from Governor Hoffman in regard to appointments of the State Board of Medical Examiners.

He announced the issuance of a supplement to the State Journal of March dealing with the public health activities of the Family Doctors of New Jersey.

Dr. H. B. Wilson spoke of the work of the Welfare Committee of the State Society and stated that any physician member was welcome to attend.

Dr. Russell K. Tether announced that the Passaic-Bergen Medical-Dental Service Bureau was about to send a letter to each member of the county society.

A motion was unanimously passed asking the Secretary to write a letter to our President, Dr. John H. Irwin, wishing him Godspeed in his recovery.

NEW MEMBERS

The following applications for membership were read:

To regular:

Dr. Francis J. Fadden, Englewood

To junior:

Dr. A. R. Judkins, Englewood

Election of New Members: The following were elected to membership:

From junior to regular:

Dr. R. J. Neville, Hackensack
Dr. Kalman Chase, Hohokus
Dr. Vincent P. Candio, Lyndhurst
Dr. Edward M. Mancene, Lyndhurst
Dr. Theodore R. Miller, Ridgewood
Dr. Vincent Costabile, Lyndhurst

To junior:

Dr. Edmund E. Jacobitti, Maywood
Dr. Sarah Gordon, Teaneck
Dr. Nelson C. Policastro, Hackensack

To associate:

Dr. Arthur P. Coca, Oradell

SCIENTIFIC

Dr. Henry Falk, Clinical Professor of Gynecology, New York University and Bellevue Hospital Medical College, Director Gynecology, Harlem Hospital, Gynecologist, French Hospital, spoke upon "Infected Abortions", which he and his co-workers have grouped in seven classes, based upon the pathology.

BURLINGTON COUNTY

Parry M. Scott, M.D., Reporter

The March meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club, Moorestown, N. J., on Thursday, March 11, the President, Dr. E. L. Small, presiding.

SCIENTIFIC

Dr. Thomas Lee, of Camden, spoke on "Office Gynecology", which he said made up a large proportion of the practice of every doctor.

In reference to leucorrhea, he spoke of four common places from which leucorrhea usually came: (1) cervix, (2) vagina, (3) urethra, (4) Bartholin's gland. He cited the rarity of the development of cancer in properly treated cases of erosions of the cervix, and to the fact that some investigators do not believe that erosion ever leads to cancer. He believes that cervical infections are a common cause, by extension, of pelvic infection but are not a source of focal infection as far as remote organs of the body are concerned.

Other pertinent points brought out by Dr. Lee were: (1) the frequency of urethral strictures in the urethritis of middle age and their improvement by dilitation and instillation of Argyrol; (2) the Schiller Test for early and easy diagnosis of cancer of the cervix; (3) the passage of a sound over the mucous membrane of a uterus in suspicious cases and the finding of blood stained discharge should make one very highly suspicious of beginning malignancy; (4) the treatment of senile vaginitis by breaking up adhesions and the use of kaolin powder, if moist, and silver nitrate, if dry; (5) the ease of examination of child-hood vaginitis by urethrascope and the recent experimental work which tends to the belief that Theelin in infants' gonorrheal vaginitis acts by causing the secretion to become acid and that just as good results may be accomplished by the use of acetic acid douches; (6) the treatment of trichomonaisis by washing the vagina with green soap and water, painting with saturated solution of silver nitrate and then tamponing with Resorcinol paste; (7) the importance of leucorrhea in childhood or early adult life with resulting metritis and sterility.

Dr. Lee then showed numerous lantern slides depicting the various conditions of which he spoke.

BIRTH CONTROL CLINIC

Dr. Curtis spoke of the poor attendance at the Birth Controll Clinic held at the Burlington County Hospital, and following discussion as to the cause of this, and as to possible remedies, it was agreed to continue the clinic.

PHYSICIANS' CREDIT BUREAU

Dr. Scott reported that the Physicians' Credit Bureau had been fully established, and that the manager, Mr. Charles Krug, of Riverside, would soon call on the individual members to obtain a list of the bad debtors and collectable bills.

The meeting was adjourned and refreshments were served.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was held March 2nd, 1937, in the Camden City Dispensary Building, Dr. B. F. Buzby, President, in the chair.

CONTRACT AND COMPENSATION PRACTICE

Dr. Reuben Sharp, chairman of the Committee on Contract and Compensation Practice, read the following report of his Committee:

"We present the recommendations for changes in the Compensation Act made to the Contract Practice Committee at an Informal Hearing on Tuesday, February 9th, 1937, at 9 p. m.

1. "It was unanimously recommended by the members of the County Society present, that the Compensation Act be changed to permit the patient to have free choice of a physician; allowing the Insurance Carrier or employer to have the right to call, in consultation, a physician of their choice, to determine whether the patient is making satisfactory progress and receiving adequate treatment.

2. Regarding State Medical Advisor to Referee. It was recommended that the man holding this position must be impartial and his services limited to Referee Work exclusively. He should not be permitted to act in consultation for Insurance Carrier or Employer. He should not be permitted to treat Compensation Cases, and later act as Medical Referee on the same case. This position should be filled on merit alone and subject to Civil Service or by tenure of office."

The Scientific Program began at 9.45 p. m. in which six papers were presented os a Symposium on Gonorrhoea:

1. From the Aspect of Ophthalmology
W. G. Mengel, M.D.
2. Acute Gonorrhea in the Male
R. S. Wright, M.D.
3. Chronic Gonorrhea in the Male
R. R. Betancourt, M.D.
4. Gonorrhea as seen by the Gynecologist
E. C. Hessert, M.D.

5. Orthopedic Aspects of Gonorhea
O. R. Carlander, M.D.
6. Relationship of Bureau of Veneral Disease Control to the Practicing Physician
A. J. Casselman, M.D.

The papers were interesting and well presented. There were 92 present, including Drs. Diverty and Shipps, delegates from Gloucester and Burlington Counties, respectively.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held Thursday evening, March 11, 1937, at the Academy of Medicine, Newark, with the President, Dr. Edgar A. Ill, presiding.

REPORT OF LUNG COMMISSION

Dr. Richard H. Dieffenbach, Chairman of the Lung Commission, presented a report which was accepted as read. (This report is printed on page — of this Journal—*Editor.*)

PROFESSIONAL AGENCY, INC.

Dr. Satchwell reported for the *Collection Ageney.* This will be known as the *Professional Agency, Inc.* The Board of Trustees will be composed of nine physicians and five dentists. Dr. Chandler was elected President; Dr. Irving Fort, Treasurer; and Mr. Parker, Secretary and Executive Director. The articles of corpoation and constitution and By-Laws have been adopted, and it is expected that this organization will start operation within a few days. Whatever charges are established at the beginning, will be reviewed at the end of three months with the view toward reduction in the charges to the lowest possible minimum.

CENTRAL ADMITTING BUREAU

Dr. Satchwell also reported for the *Central Admitting Bureau.* A tremendous amount of work has been done in connection with this organization to find out the costs of admitting departments in the various hospitals, and to compare these costs with the proposed costs of the Bureau. It is hoped that a complete report on this work can be given to the Society in the very near future.

SCIENTIFIC

Dr. E. J. Ill, President, introduced the principal speaker of the evening, Dr. Samuel J. Kopetsky, of New York, who gave an address on the subject. "The Roll of Organized Medicine in the Present Era", (This address will be published in an early issue of the Journal.—*Editor.*)

NEW MEMBERS

The following new members were elected:

Regular

August V. Belott, 129 Main Street, West Orange, University of Buffalo, 1931.

Charles Wallack, 66 Baldwin Avenue, Newark, University of Maryland, 1929.

Associate

Bernard Bolten, 326 Peshine Avenue, Newark, St. Louis University Medical School, 1934.

Robert P. Fruchbaum, 205 Franklin Avenue, Nutley, University of Maryland, 1935.

Leo Schneider, 83 Wolcott Terrace, Newark, St. Louis University, 1933.

William F. Wangner, 20 Warren Street, Bloomeld, University of Michigan, 1935.

THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

Franklin J. Tobey, M.D., Secretary

The stated meeting of the *Academy of Medicine of Northern New Jersey* was held on Thursday, January 21, 1937, under the auspices of the Section on *Obstetries and Gynecology,* being called to order by President Danzis at 9 p. m.

NEW MEMBERS

The following candidates were elected to Junior Fellowship:

Gerald Hayes, M.D., 86 Hawthorne Avenue, East Orange

Barney Schaffer, M.D., 252 Washington Avenue, Belleville

George Urbach, M.D., 297 Seymour Avenue, Newark

SCIENTIFIC

Dr. Danzis welcomed the members of the Maternal Welfare Committees of New Jersey to the Academy and introduced Dr. Edward G. Waters, Chairman of the Section.

Dr. Waters introduced Dr. Walter C. Dannreuther, Professor of Gynecology and Obstetrics, New York Post-Graduate Hospital.

Dr. Dannreuther's paper, "Supra-vaginal Hysterectomy", covered the subject thoroughly and scientifically and was of great interest to the audience. A brief discussion by Drs. E. J. Ill, Danzis, Blackburne, Waters, and Gerendasy followed.

The stated meeting of the *Academy of Medicine of Northern New Jersey* was held on Thursday, February 18th, 1937, under the auspices of the *Eye, Ear, Nose, and Throat Section.*

President Danzis called the meeting to order at 9:15 p. m.

The following were appointed as the Nominating Committee of the Academy: Sidney C. Keller, M.D., Chairman, Newark; Charles F. Rathgeber, M.D., East Orange, and William H. Areson, M.D., Montclair.

Dr. Danzis introduced Dr. Samuel T. Hubbard, Chairman of the Section.

Dr. Hubbard announced the Nominating Committee of the Section: E. P. Cardwell, M.D., Chairman; E. S. Sherman, M.D., and W. F. McKim, M.D.

SCIENTIFIC

Dr. Hubbard introduced Ward J. MacNeal, Ph. D., M.D., Director of Laboratories of Pathology and Bacteriology, New York Post-Graduate Medical School and Hospital.

Dr. MacNeal's paper, "Recent Experiences with Bacteriophages and Other Bacteriotherapeutic Agents", described a large number of cases and their treatment. This discourse was of unusual interest to the audience. At the conclusion of the paper, it was discussed by Clarence H. Smith, M.D.,

F.A.C.S., Professor of Clinical Oto-laryngology, New York Post-Graduate Medical School and Hospital, and M. J. Fein, M.D., Brooklyn, N. Y., Pathologist. Mountainside Hospital, Unity, Wickersham, Adelphia, etc.

The twenty-sixth anniversary meeting of the *Academy of Medicine of Northern New Jersey* was held on Thursday, March 18th, 1937.

President Danzis called the meeting to order at 9:15 p. m.

ELECTIONS

The following physicians were elected to Fellowship:

Lorrimer Armstrong, M.D., 121 S. Euclid Avenue, Westfield

Angus M. Brown, D.D.S., 516 Broad Street, Newark

Watson B. Morris, M.D., 193 Morris Avenue, Springfield

Max Singer, M.D., 147 Johnson Avenue, Newark

Junior Fellows elected were:

William M. Epstein, M.D., 31 Lincoln Park, Newark

Paul William Haley, M.D., 781 Sanford Avenue, Newark

Vincent J. Strack, M.D., 1072 South Orange Avenue, Newark

John J. Torppey, M.D., 472 Sanford Avenue, Newark

William Zimmer, M.D., 83 Vassar Avenue, Newark

The Nominating Committee made the following selections for officers:

President (two years), Henry C. Barkhorn, M.D., Newark

Vice-President (two years), Charles M. Robbins, M.D., Newark

Treasurer (two years), Lee W. Hughes, M.D., Newark

Secretary (two years), Franklin J. Tobey, M.D., Newark

Trustees (five years), Max Danzis, M.D., Newark; E. Zeh Hawkes, M.D., Newark

Trustee (four years, to fill the vacancy caused by the death of Dr. John F. Hagerty), Arcangelo, M.D., Hackensack

Committee on Admission (five years), Royal Schaaf, M.D., Newark

Library Committee (five years), Abraham Wolfson, D.D.S., Newark

These nominees were unanimously elected.

MEMORIAL FLAG

Dr. Danzis presented an American flag, a gift of Mrs. Emanuel D. Newman, in memory of the late Dr. Emanuel D. Newman, Secretary of the Academy 1913 to 1934. Dr. Edward J. Ill, first President of the Academy and present President of the Trustees, accepted the flag for the Academy and thanked Mrs. Newman. He spoke of Dr. Newman's loyalty to the Academy and said that the presence of the flag would always be a reminder of his unselfish service, as well as a source of patriotic inspiration.

LIBRARY

In introducing Mr. August Hamberg, President of the Board of Trustees of the Newark City Library, Dr. Danzis called the attention of the audience to the fact that the medical library of the Academy was open to the laity and the allied professions. He stated that due to the generosity of the present City Commission and the Trustees of the City Library, it had been supported by the city during the past year. During the depression, the Academy had assumed this expense.

Mr. Hamberg spoke of the rapid growth of the medical library and its civic importance. He described our City Library as one of the best in the country and the first to establish a commercial branch.

ANNIVERSARY DISCOURSE

Dr. Danzis introduced Dr. Robert C. Clothier, President of Rutgers University, who delivered the Anniversary Discourse.

Dr. Clothier spoke of the educational problems of the youth of today. His remarks showed an extensive knowledge of his subject, delivered with humor which delighted his audience.

At the conclusion of the address, Dr. Danzis announced that a collation would be served, and thanked the Woman's Auxiliary to the Essex County Medical Society for their hospitality.

LECTURE

The Committee on Public Health and Medical Education announces a lecture to the laity at the Academy of Medicine, 91 Lincoln Park, South, Newark, on Thursday, April 22nd, 1937, on "The Evolution of the Human Brain", by Frederick Tilney, M.D., Professor of Neurology and Neuro-anatomy, Columbia University.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

Members of the *Gloucester County Medical Society,* meeting on March 18, in the Georgian Room at the Homestead Coffee Shop, heard an interesting address by Dr. Temple Fay, of the Temple University Medical School, on the subject "Mechanism of Headache, Its Diagnosis and Treatment."

POST-GRADUATE

The Committee on Post-Graduate work reported that the first of post-graduate courses offered by the state's medical societies in co-operation with Rutgers University Extension Service was held yesterday. The course will be held each Wednesday for six consecutive weeks, and will be addressed by men outstanding in the medical profession.

Following the meeting a buffet supper was served, at which members of the auxiliary were guests.

The following members were present: Drs. E. E. Downs, Paul Burkett, Harry Nelson, William Brewer, Dorothy Rogers, Paul M. Pegau, Fuller G. Sherman, H. B. Diverty, J. Harris Underwood and J. F. Hughes, of Woodbury; Oram A. Wood, Anthony DiMarino and H. H. Hunter, of Paulsboro; William Pedrick, Glassboro; W. J. Burkett, I. W. Knight and H. W. Wright, of Pitman; T. M. Gairdner and C. I. Ulmer, of Gibbstown; Don Weems, of Wenonah; R. K. Hollinshed, and I. N. Patterson, of Westville; W. G. Harris, of Mullica Hill, and A. G. Gillis, of Clayton.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held on Tuesday, March 2, 1937, at the Carteret Club.

SCIENTIFIC

President Evans introduced Charles Gordon Heyd, M.D., F.A.C.S., Professor of Surgery, New York Post Graduate Medical School, Columbia University, and President of the American Medical Association, who spoke on the subject, "Classification and Treatment of Goitre". Discussors: Drs. Lobban, Jaffin, Fellman, Spence, Swiney, Alter, and Pearlstein, and closed by Dr. Heyd.

COMMUNICATIONS

Dr. J. L. Evans: "We have a letter here in regard to the distribution of public funds for public health services, from Dr. Stanley Nichols, Chairman of the State Public Health Committee. I believe that there is an understanding between the Medical Society of New Jersey and the State Relief authorities to pay physicians to treat indigents. It is somewhat similar to the E. R. A. I understand that there is also an agreement to also pay the hospitals. Whatever develops along that line, we will try to inform you."

By Dr. J. H. Rosecrans: "It has been arranged that at the next meeting we will have a *"Cancer Night"*. I have been appointed by the State Society, and I have asked and have gotten the consent of Dr. William P. Healy, who is going to discuss the 'Use and Misuse of Radiation in Cancer of Uterus', and also Dr. Fred W. Stewart, who is going to discuss 'Recent Experimental Approaches to Causation of Tumors'. I think it will be a very interesting program. That will be for the next meeting, the sixth of April."

By Dr. Evans: "That program will be published in the next issue of the Bulletin and I would like those who are interested to prepare for a discussion of the paper and if you will let the Secretary know before hand that you would like to discuss it, we could probably have a more frank discussion."

MEMORIAL TO DR. SALMON

By Dr. Evans: "Would like to call your attention to the death of Dr. Edward H. Salmon, who died the 28th of February. He was Chief of the Health Bureau for the past thirteen years. The Secretary will have published the usual notice in the next issue of the bulletin."

CONSTITUTION AND BY-LAW REPORT

The following amendments were read and adopted:

1. Amend the last sentence of Article 4 of the Constitution to read:

"The Regular Meeting in May shall be the Annual Mecting, at which meeting the election of officers shall be held."

2. Chapter III, By-Laws, Section 1, to read:

"The Officers, Delegates and Elective Committees of this Society shall be elected by ballot at the Annual Mecting in May and shall be installed immediately at the end of this meeting."

3. Change the first paragraph of Chapter III, Section 2 of the By-Laws:

"The Nominating Committee shall announce its nominations for the various officers at the March meeting and the membership shall be notified of them in the notice for the April meeting. Additinal nominations may be made from the floor at the April meeting. At the close of the April meeting no further nominations shall be made for the Annual Meeting."

4. Add Section 2 (d) to Chapter IV of the By-Laws:

"The Executive Committee shall have power to fill vacancies in all offices and elected standing committees until the next annual meeting."

5. Change Section 4 of Chapter IV of the By-Laws to read:

five members, elected at the Annual Meeting. The Committee shall be nominated from the floor at the April meeting."

Dr. J. F. Norton moved the adoption of these amendments to the By-Laws, seconded and carried.

REPORT OF NOMINATING COMMITTEE

Dr. W. T. Callery reported the following nominations for the ensuing year:

President, W. L. Williamson
Vice-President, R. L. Ballinger
Treasurer, H. Spence
Secretary, T. McG. Brennock
Reporter, J. N. Connell

Board of Trustees, 3 years to 1940:
T. J. Schuck — A. J. Conty

Board of Censors, 3 years to 1940:
A. E. Jaffin

Audit Committee, 3 years to 1940:
M. J. Weiss

Members of Publication Committee, 3 years to 1940:
S. R. Woodruff — S. A. Cosgrove
W. T. Callery — W. J. Snyder

Delegate to State Nominating Committee to serve 1938:
J. F. Londrigan

Alternate:
F. J. McLoughlin

Member of Committee on Constitution and By-Laws, 3 years to 1940:
A. P. Hasking

Members of Legislative Committee, 3 year to 1940:
B. S. Pollak — D. I. Nalitt
A. E. Kuhlmann

Members of Public Health Committee, 3 years to 1940:
C. P. DeFuccio — E. Halligan
A. E. Jaffin

Delegates to State Convention, 3 years to 1940:
A. P. Hasking — W. A. Pinkerton
J. F. Londrigan — G. S. Kerdasha
J. F. Norton — F. J. McLoughlin
H. J. Perlberg — D. B. Street

Alternates to State Convention, 3 years to 1940:
L. L. Perkel — C. M. Wolbert
G. Ginsberg — E. J. Daly
V. J. Sheeran — P. A. Simcone
S. B. Barishaw — E. Halligan

Election Committee, to serve 1938:

S. G. Scott	P. J. Bononno
L. A. Schneider	M. Shapiro
D. D. Dougherty	S. S. Schept
W. M. Doody	

Members of Maternal Welfare Committee, 3 years to 1940:

A. A. Mutter	P. D'Acierno
J. H. Jentz	

PUBLIC HEALTH COMMITTEE REPORT

Dr. A. E. Jaffin gave the following report:

"At the last annual meeting of the National Tuberculosis Association, in New Orleans, one author stated: "There is probably no wider field of usefulness in the general practice of medicine, than that of tuberculosis." This usefulness can best be applied to the early diagnosis and prevention of the disease. All efforts on behalf of those already suffering from manifest disease are but attempts to make the best of a bad situation, and are best left either entirely to the phthisiologist, or carried out under his direction.

The prevention of tuberculosis is today no longer a matter of better housing and higher living standards, for even with the achievement of both of these, the problem has not yet been solved, and tuberculosis is still found amongst the rich as well as the poor. The general practitioner in medicine must be prepared to meet his responsibility in this problem.

Amongst other things, this will require the knowledge of the significance of a positive tuberculin reaction, and a realization that no diagnosis of the presence or absence of tuberculosis is justified without an X-Ray of the chest. In view of the fact that tuberculosis begins to manifest itself in a great majority of cases, between the ages of 15 and 25, and that usually when it is encountered, it is already more or less advanced, there is a general agreement that measures for earlier recognition of these cases must be used.

Plans are now under way to approach this important public measure by means of the Mantoux Test, and the X-Ray of all High School students, the great majority of whom would fall within these age groups. Reports of the findings will be sent to the private physician wherever possible; and the students will be referred back to him for the necessary supervision and follow-up.

While, at first, only the Jersey City High Schools will be investigated, comprising some 17,500 pupils, it is hoped that this will be soon extended to the rest of the County. Every physician in Hudson County can, by means of his personal interest and coöperation, accomplish a great deal to make this survey a success.

Reports are coming in from many physicians in the northern end of our County, of patients coming to them for periodic examinations, as a result of similar surveys made recently in Bergen County.

An opportunity is being offered to the members of the society to familiarize themselves thoroughly with the procedures involved. While the technical part of the program will be under the supervision of the Chairman of the Public Health Committee and his associates in the Tuberculosis Clinics, it would be desirable to recruit as many more qualified physicians as the circumstances may demand. We are fortunate in having the interest and hearty coöperation of Mayor Hague, through whose efforts the facilities of the Board of Education and its Medical Department, as well as those of the Department of Public Affairs, will be at our disposal. The undertaking is being sponsored by the Board of Managers of the Hudson County Tuberculosis Hospital and Clinics, and the Hudson County Medical Society. A good part of the cost of the undertaking will be borne by the Hudson County Tuberculosis League, by means of the Xmas seal funds which are set aside for that purpose."

Abraham E. Jaffin, M.D., *Chairman*
Public Health Committee, of the
Hudson County Medical Society,
Chief of Clinics.
Hudson County Tuberculosis Clinics.

By President Evans: "You should realize that this committee is really going out and finding patients for you. It has been my experience that, as a result of the Bergen County drive, a number of patients have been directed to me for my care. It means that in doing this work they are really going out and finding patients for you that you probably wouldn't have got otherwise. Aside from the good work in preventing tuberculosis, it will have a very good economic result.

Dr. B. S. Pollak: "I merely desire to emphasize one point and that is that this study is undertaken for the purpose of diagnosis and treatment among the teen age group. It is our ardent hope and sincere desire to have the interest of the Doctors in this County Society in this movement, and it is for that reason that, through our suggestion, the State Medical Society has adopted this scheme through the medium of its Public Health Committee. Several counties have already undertaken this method of procedure. We devoutly hope that our physicians will avail themselves of the opportunity of affiliating themselves with us. We will compensate them with an adequate income.

We do not intend to practice medicine nor do we intend to interfere with the rights of the family physician. The project will be conducted in a most ethical manner, and with the approval of the State Society. I shall be very happy to discuss this with anyone, for it is being undertaken primarily through the suggestions of the Public Health Committee. The following groups will act as a unit: The Public Health Committee of the Hudson County Medical Society, the Officials of the Tuberculosis Hospital and Clinic, the Medical Society of New Jersey and the Tuberculosis Organization (lay) which is donating a great sum of money for the laity as well as the profession, and is furnishing means whereas the compensation of physicians is accomplished. We are most desirous of having your coöperation and that we will attain this in the manner in which we have indicated."

By President Evans: "Those of you who are interested in doing this work, give your name to Dr. Jaffin so he will have some definite personnel to go on and if you will do this we will get something definite. I think Hudson County has been

a good bit behind the rest of the State, and there is no reason why we shouldn't do as much or more work in this County."

DINNER COMMITTEE REPORT

Dr. W. L. Williamson gave the following report on the Annual Dinner, held at the Carteret Club, January 27, 1937:

Tickets Sold, 174	$435.00
Expenses	399.45
Profit to the Society	$35.55

SCHOOL PHYSICIANS' COMMITTEE

Drs. Joseph Shapiro and Sydney Chargas introduced the following Resolution:

RESOLVED, that the president of the Hudson County Medical Society hereby appoint a committee of five members engaged in school health work in the Public or Parochial Schools of Hudson County, to be known as *The Hudson County School Physicians Committee.* That this committee report from time to time to the Hudson County Medical Society on school health activities and such phases of school health that will be of interest and concern to the members of the Hudson County Medical Society,

And Be It Further Resolved that the Hudson County Medical Society be apprised on such public Health problems and measures that may from time to time be promulgated in the Public or Parochial Schools, so that the Hudson County Medical Society may be in a position to intelligently exercise a directing and beneficient influence on the welfare of the physicians of Hudson County, and upon the health and welfare of the school children.

Dr. Pollak moved the adoption of this resolution. Seconded and carried.

By President Evans: "I was shown a bill in Trenton on Sunday, February 28th, when Dr. Pollak, Dr. Spence and myself attended a meeting of the Welfare Committee of the State Society in Trenton—a bill authorizing principals of schools, teachers and nurses to examine eyes and ears of school children. It is rather a vicious sort of bill, but I know the Welfare Committee is going to oppose that bill. I might briefly summarize the work that is being done by the State Welfare Committee.

"They had rather a long report on the nurses, to which you will find a reference in the State Journal of March, page 191, and also a report on the proposed Federal legislation for pure food and drugs. The concensus of opinion favored the Wiley Act with some amendments rather than the Copeland Bill as written. In general, the Welfare Committee is alive to the many problems which affect The Medical Society of New Jersey."

Question called.

PROPOSAL OF NEW MEMBERS

Benjamin P. Abrams, 919 Washington St., Hoboken
Dante P. Crisonino, 12 West 41st St., Bayonne
John J. Danielson, 977 Bergen Turnpike, N. Bergen
J. D. Goldstein, 2801 Boulevard, Jersey City
John Higgins, 145 Highland Ave., Jersey City
Thomas F. Lane, 155 Garrison Ave., Jersey City
John J. Mackin, 596 Bergen Ave., Jersey City
Michele Tomaiuoli, 70 32nd St., North Bergen

Regularly moved and seconded they take usual course. So ordered.

ELECTION OF NEW MEMBERS

John Coughlin, 43 Arlington Ave., Jersey City
Joseph P. Donnelly, 1 Madison Ave., Jersey City
David J. Flicker, 343 Kearny Ave., Kearny
Hyman Frieman, 744 Avenue C, Bayonne
Harry E. Gerner, 2787 Boulevard, Jersey City
Alfred Goldsmith, 240 29th Street, North Bergen
Richard Good, 949 Park Ave., Union City
Harry J. Kelly, 311A Brown St., Union City
Joseph S. Grewal, 140 E. 52nd St., New York
Charles Lipshutz, 804 Avenue C, Bayonne
Martin J. McDonnell, 24 30th St., North Bergen
Stephen A. Mickewich, 650 Avenue C, Bayonne
Bernard Milnis, 980 Broadway, North Bergen
Sol Pollack, 4042 Boulevard, Union City
Charles M. Wolbert, 4411 Boulevard, Union City

Transferred from Union County Medical Society to Hudson County Medical Society: Dr. Stewart L. Goodrich, 812 Avenue C, Bayonne.

Meeting adjourned 11:25 p.m.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met in the Trenton Country Club on March 10th, President D'Arcy presiding.

SCIENTIFIC

Dr. Blaugrund, Chairman of the Program Committee, introduced the speaker, Stanley Nichols, M.D., Chairman of the State Public Health Committee, who delivered a most instructive discourse on the subject "The Place of the Family Physician in Public Health Program".

Dr. Nichols spoke in reference to the physician as an "Individual" and as a "Loyal County Society member" in the process of education which Organized Medicine is at the present time energetically insisting upon each and every member of the profession.

The speaker elaborated upon the several fields of practice, enumerated in recent letters sent out over his signature, and appearing in the Journal of February and March.

The informal discourse upon each division, with its many subdivisions, was made most interesting and instructive by the manner in which Dr. Nichols defined and explained the many problems arising in the carrying out of so great and so inclusive a program.

Especial emphasis was placed upon the Public Health Hour and upon the insistance of regular health examinations, as in this way the close relationship between patient and physician will be maintained, and confidence strengthened with assurance sustained.

Several questions were propounded, all of which Dr. Nichols answered in a most satisfactory manner and with perfect acquaintance with the subject under discussion.

Dr. Haggerty, in expressing his appreciation of the privilege of listening to Dr. Nichols, moved that the society go on record as endorsing the work of the Public Health Committee, which motion carried with emphasis.

Dr. Wilkes called attention to the various articles appearing in the State Journal which describe in detail the progress being made by this committee throughout the State.

EXECUTIVE COMMITTEE

The Executive Committee report, embodying and endorsing the several suggestions and recommendation of State committeemen was read, and the recommendations therein were approved.

FINANCES

The Treasurer reported excellent condition of finances, and referred to the necessary increase in State dues for the carrying on of these many projects relating to Public Health Program.

SPEAKERS' BUREAU

Dr. Watts reported that about forty-five responses had been received relative to the Speakers' Bureau, and requesting further information.

POST-GRADUATE

D. Purcell gave a very comprehensive report on the registration for the post-graduate courses, stating that about sixty members had so far signed for the lectures.

Following the reading of an authorization from Secretary Morrison relative to the election of additional Delegates to the House of Delegates, the President announced that nominations were in order for this office.

Dr. A. James Fessler was duly nominated and regularly elected as a Delegate, and Dr. J. L. Wikoff, Alternate Delegate.

Following the motion to adjourn, Dr. Frank Scammell invited the members to partake of refreshments, the occasion being the advent of his second grandson.

MIDDLESEX COUNTY

Charles H. Calvin, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on Wednesday evening, March 17th, 1937, at "The Pines" in Metuchen, and was called to order by the President, John H. Rowland, M.D.

SCIENTIFIC

Dr. Irving Sherwood Wright, Assistant Professor of Clinical Medicine and Chief of the Vascular Clinic at New York Post-Graduate Medical School, Assistant Editor of the American Heart Journal, Secretary of Section on Pharmacology and Therapeutics of the American Medical Association, spoke on the subject of "The Present Status of the Treatment of Peripheral Vascular Diseases", which he illustrated with lantern slides.

Dr. Sherwood dwelled particularly on the four conditions—thrombo-angitis obliterans, arteriosclerosis, Raymond's disease, and eye thromelalgia. He outlined the use of Acetyl-Beta-Methylcholine chloride (Mecholyl-Merck) for its vaso-dilating effect; and the use of atropine to counteract its unpleasant effects, such as flushing of the face, low blood pressure, salivation, and sweating.

PUBLIC RELATIONS COMMITTEE

Dr. Sherman, Chairman, moved for an enlargement of the Speakers' Bureau. The following speakers, under the Public Relations Committee, are listed for the month of March:

Dr. Molitch—Odd Fellows, Cranbury
Dr. Gessner—St. Paul's Parochial School, New Brunswick
Dr. Fine—Kiwanis, Perth Amboy
Dr. Uhr—Bayard School, New Brunswick
Dr. Sherman—Franklin School, Highland Park
Dr. McKiernan—Lions, South River
Dr. Taber—Y. M. C. A., Perth Amboy
Dr. Kler—P.-T. A., New Brunswick
Dr. McLeod—Y. M. C. A., Perth Amboy
Dr. Pellican—Mothers' Club, Sewaren
Dr. Pellicane—Shelton School, Gibbstown
Dr. Fine—Y. M. C. A., Perth Amboy

PUBLIC HEALTH COMMITTEE

Dr. London, Chairman, read a report of the Committee on Venereal Disease Control presented by Dr. McKiernan at the last meeting, which had been referred back to the Public Health Committee for reconsideration (Jour. March, p. 211). The subjects were voted on separately as follows:

1. That all new health officers appointed in all municipalities in Middlesex County should be doctors, with some training in health work; and lacking that, to acquire that training which is available at Rutgers College. Approved.

2. That the utmost newspaper publicity be employed and frank discussion of social diseases take place through the newspaper columns in an effort to awake in the general public a greater consciousness of the phases of these diseases. The pronounced effort in the past to suppress this information is condemned. Approved.

3. That key venereal disease clinics should be established at designated points, these points outside of New Brunswick, to be Perth Amboy and South River. There should be a staff of doctors, trained in this special work, with one supervising head. Not approved.

CARTERET PLAN

Dr. London read a letter, known as the Carteret Plan, stating that the State and local Board of Health had appointed Drs. Strandberg and Kemeny, of Carteret, to take care of venereal cases in their offices at $1.25 per person. From the trend of the letter it appeared the other Carteret physicians were not interested. A motion to that effect was not passed, but instead a motion stating that any doctor in Carteret may treat these patients in his office at $1.25 per patient, was passed.

MATERNAL WELFARE

Dr. Grieves, Chairman, read a report on maternal welfare for Middlesex County, which was placed on file.

Refreshments were served at the close of the meeting.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A regular monthly meeting of the *Morris County Medical Society* was held the evening of March 18th at the Morristown Memorial Hospital, with President Sherman presiding over an attendance of about fifty.

After a brief business session, the President turned the program over to Dr. Haven for the presentation of medical and surgical subjects by the staff of Morristown Memorial Hospital.

ADDITIONAL DELEGATES

A letter was read from State Society Secretary Morrison stating that, upon the basis of eighty-three members with dues paid, the society is entitled to six delegates. Accordingly, Dr. F. Clyde Bowers, of Mendham, and Dr. R. L. Gilbertson, of Madison, were duly elected to serve for 1937, with the four other delegates already designated.

SCIENTIFIC ON INSULIN

Dr. Larson initiated the scientific chapter on the subject of "Insulin" and "Boiling down" the literature to a sort of "Elementary primer on what we seem to know about insulin, and designed to remind us of the things we have known for a great while and I don't think we can afford to forget, if we are going to use insulin with best results on our patients". He said that, in the use of insulin in diabetes, the prime factor is not insulin but that it is diet; that diet always has been and still is the prime factor in the treatment of diabetes; that he was surprised occasionally to find patients being given insulin without proper diet treatment. Dr. Larson explained the difference between the "old" and the "new" insulin, indicating its use in other cases, and emphasizing that there is no other drug of any value in the treatment of diabetes.

LUNG ABSCESS

A case of primary and secondary "Lung abscess", with pictures, was presented by Dr. A. F. Bowers, of Mendham, on the medical side; and was followed by Dr. L. E. Williams, of Madison, on the surgical side. The case was of particular interest because of its coming to the hospital from a tuberculosis institution, with persistently negative sputum, with an opportunity to observe the development from the beginning, whereas more usually these cases come into the hospital with the abscess developed.

TWO TUMOR CASES

Two interesting cases of tumor were presented, one the giant cell type by Dr. Voss, and the other by Dr. Bivas of the hospital staff,—their painstaking presentations being illustrated by pictures.

Dr. Grant Thorburn, of Mendham, Associate Consultant of Morristown Memorial, participated and gave freely of his knowledge on the subjects presented and of his experience at Bellevue Hospital with similar cases.

THE APRIL MEETING

The April meeting will be of the recreationally instructive type to be held at Spring Brook Country Club, Morristown, with Dr. Dittmars, of New York Zoölogical Gardens, guest speaker.

OCEAN COUNTY

Robert McC. Halbach, M.D., Reporter

The March meeting of the *Ocean County Medical Society* took the form of a dinner dance on Saturday evening, March 6th, 1937, at the Laurel-in-the-Pines Hotel, Lakewood, with the ladies of the Auxiliary to the County Society as guests. Honorary guests included President Spencer T. Snedecor and Mrs. Snedecor, President-Elect William G .Herrman and Mrs. Herrman, and Counselor James A. Fisher, of Asbury Park.

DINNER DANCE

Except for several unavoidable absences, all members of the society attended the function, which included an excellent banquet, and an exceptionally fine floor show from New York City, and dancing. At the close of the banquet, Dr. Robert Buermann, our President, thanked the Entertainment Committee, of which Dr. Adolf Towbin is Chairman, for the fine evening which they provided, and made a few very appropriate remarks as to the great progress the society had made during the past year both in the way of increased membership and attendance, as well as for the excellent speakers which had been obtained for the scientific programs.

SPEAKERS

Dr. Buermann then called upon President Snedecor, of the State Society, who in his usual easy and conversational style reviewed the work which the State Society was doing, not only to maintain high standards in the practice of medicine, but also protect the interest of each individual doctor from any improper encroachment.

President-Elect Herrman was next introduced by Dr. Buermann, and made some very enjoyable remarks along a somewhat lighter vein. He paid great tribute to the all-too-frequently over-looked assistance which the doctor's wife is constantly rendering; and read a short original poem in support of this theme.

Dr. James A. Fisher, Counselor for the Fourth District, was next introduced and made our ears rather burn with praise he gave for the type of medicine being practiced in Ocean County, and for the high standards of our hospital service.

Dr. Buermann introduced Mrs. Theodore Thompson, President of the Ladies' Auxiliary, and thanked her for the magnificent way in which the ladies of the society had been coöperating. Mrs. Thompson thanked the society for its appreciation of the Auxiliary's work and expressed the hope that they mighe be of even greater service during the balance of the year's activity.

The rest of the evening was given over to entertainment and dancing.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

A combined dinner and meeting of the *Passaic County Medical and Dental Societies* was held at the Ritz Restaurant, 711 Main Avenue, Passaic, N. J., on Thursday evening, March 11, 1937.

Due to evening office hours, there were only a few physicians present at the dinner, unfortunately, but the evening session was well attended by both groups.

SCIENTIFIC

Dr. Boyco introduced the speaker of the evening, Dr. James R. Cameron, Professor of Oral Surgery, Temple University Dental School, and Chief Oral Surgeon at the Pennsylvania Hospital, Philadelphia, who spoke on "Lesions of the Mouth of Interest to Both Professions". In his introductory remarks, he told how dentistry became separated from the practice of medicine through a misunderstanding on the part of the head of a medical school. Now, he said, we are rapidly approaching a unanimity of approach and realization that dentistry is a special branch of medicine. He gave numerous instances where mistakes were made by the dentist in treating what appeared to be a local dental problem when, as a matter of fact, the lesion was part of a systemic condition which should have been recognized. Likewise, he told of mistakes made on the part of physicians in not recognizing the oral manifestations of systemic disease. He made a plea for a more wholehearted coöperation on the part of the physicians and dentists for the welfare of the patient.

Dr. Cameron then gave a splendid review of the most common oral lesions and their treatment. He concluded with a lantern slide demonstration. His discussion was well received, and everyone realized that the meeting had been a success. A lively discussion followed his presentation.

BUSINESS

The business session of the Passaic County Medical Society was then held, Dr. Norman Dingman presiding. Owing to the lateness of the hour, Dr. Dingman announced that a nominating committee would be appointed for nomination of officers for the coming year, and that a motion to adjourn would be in order. The meeting was thereupon adjourned.

SUSSEX COUNTY

August H. Groeschel, M.D., Reporter

A special meeting of the *Sussex County Medical Society* was held Thursday evening, March 18th, at the Sussex Inn, Sussex, N. J. The meeting was called to order by President Warren Smith, who explained that the purpose of the meeting was to discuss the problem of the treatment of indigent patients suffering from venereal diseases in Sussex County.

No free clinic for the treatment of venereal diseases exists in Sussex County, and the State Department of Health and several social welfare agencies interested in the problem have recently expressed a desire for coöperation from the medical society in the formation of some plan through which these patients may receive treatment, the expense of which might be borne jointly by the county, and by appropriations from Federal funds, through the Social Security Act.

A lengthy discussion ensued which brought to light the following facts:

Although it was impossible to state definitely because of the lack of statistical data, it was the impression of most of the members present that the total number of cases of first and secand stage syphilis was very small.

The total number of cases of tertiary syphilis (in which Public Health Department's interest is not particularly keen) was also very small. Routine Wassermann tests on employees of the N. J. Zinc Co. show about one per cent incidence of tertiary syphilis.

No definite information on the extent of acute or chronic gonorrhoea was available.

The Society was definitely against the establishment of a free clinic for the treatment of these cases, the doctors preferring to do the work free of charge in their own offices.

A committee was appointed by the President to contact the representatives of the social welfare agencies in order to obtain from the further information as to the extent of the problem as found by their researches, and to formulate a plan whereby the medical society could assist and coöperate in the handling of the situation. This committee is to report at the April meeting.

The meeting adjourned after the disposition of minor business and refreshments.

THE WOMAN'S AUXILIARY

THE AUXILIARY AT THE ANNUAL MEETING

Wives of doctors attending the Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey to be held in Atlantic City on April 27, 28, and 29, will be royally entertained with a round of card parties, luncheons, receptions, and teas, and a fashion show. Mrs. Carl Surran, General Chairman of the local Committee on Entertainment, has announced the following list of committee chairmen of local committees on entertainment:

Mrs. Samuel Salasin,—Program and Printing
Mrs. Lawrence Wilson,—Convention Treasurer
Mrs. Raymond Williams,—Tickets and Reservations
Mrs. Abraham Jaffin,—Credentials
Mrs. Clarence Whims,—Music
Mrs. Baxter T. Timberlake,—Flowers
Mrs. G. Ruffin Stamps,—Prizes
Mrs. Charles Kaighn,—Rolling Chair Rides
Mrs. William O. Roop,—Musical Tea
Mrs. Daniel C. Renyer,—Fashion Show
Mrs. Ily Beir,—Arts, Hobbies and New Jersey History
Mrs. Robert Bradley,—Reception, Banquet and Ball
Mrs. Levi Walker,—Auxiliary Luncheon
Mrs. Percy Clark Joy,—Bridge Party
Mrs. William Carrington,—Telephone
Miss Betty Brown,—Junior Aides

Mrs. Surran is also chairman of the local Committee on Arrangements for the Annual Meeting of the National Woman's Auxiliary, to be held in Atlantic City June 7-11, 1937. An organization meeting to arrange for the convention was attended by twenty-four members, including three from other states.

A NEW CALENDAR

Mrs. George A. Rogers, President, has published a most useful booklet, the form of which promises to become a permanent guide in the Auxiliary's future work. It contains the names of the officers and directors for the year, a calendar of the meetings of each branch, a substantial program for the Public Health and Public Relations Committee, and a Speakers' Bureau. The obligations of the County Presidents and of all members of the various auxiliaries are concisely stated. Important data on increase in membership is also given. To make the aims and the methods of accomplishing the ends complete, an excellent outline, written by Mrs. Beir, on the work of the Committee on Arts, Hobbies, and Medical History, is included.

This booklet is printed in a unique form, for ready reference. Each of its eight leaves is printed on paper of a distinctive color; its edge is cut back about one-third of an inch, beginning with the last; and the subject of each leaf is printed on the exposed edge for ready reference. The contents of the pages are as follows:

1. Officers of the State Auxiliary.
2. Calendar of meetings of the State Auxiliary, and of each of the county auxiliaries.
3. Suggested program of the committees on Public Relations and Public Health.
4. County Chairmen of Speakers' Bureaus.
5. Obligations of County Presidents, by months.
6. Membership obligations.
7. Program of Art, Hobby, and Medical History Committee.
8. Suggested literature for reading.

THE WOMAN'S AUXILIARY EXECUTIVE BOARD MEETING

The *Executive Board Meeting of the Woman's Auxiliary to the Medical Society of New Jersey* was held at the Essex House, Newark, Monday, March 8th, at 10:30 a. m., Mrs. George A. Rogers, the President, presiding. Twenty-seven members were present.

REPORTS OF COMMITTEE CHAIRMEN

Arts, Hobbies and Historical.—Mrs. Beir, Chairman, gave a résumé of her plans for the Exhibit at the Annual Meeting, and additional instructions to the counties. Responses from letters sent out to the various counties had been very encouraging, and this year's Exhibit bids fair to surpass all previous Exhibits with a larger room for displaying artcles, and a much improved lighting arrangement for paintings.

Credentials.—Mrs. A. E. Jaffin, Chairman, asked that the County Presidents send to her as soon as possible the names of their respective delegates and alternates.

Historian.—Mrs. James Hunter, Chairman, was

unable to be present. Mrs. Ely and Mrs. Jaffin reported that they had sent in a name for "The Book of Memories".

Legislation.—There are bills affecting some cults, amendments to the Workmen's Compensation Act, and one enabling the Boards of Freeholders to purchase land on which to build Cancer Treatment Hospitals, and bills affecting the Department of Health, but these bills at the present time remain in committee.

Clip sheets are sent out from time to time, from the State Federation of Women's Clubs, which individual members should read carefully .

Nominating Committee.—Mrs. Frederick A. Kinch, Chairman, reported the following nominations to be presented at the Annual Meeting of the State Auxiliary:

President-Elect, Mrs. Don A. Epler, Essex
First Vice-President, Mrs. A. E. Jaffin, Hudson
Second Vice-President, Mrs. G. E. McDonnel, Burlington
Recording Secretary, Mrs. Dan S. Renner, Somerset.
Treasurer, Mrs. Thomas P. McConaghy, Camden
Directors (three years): Mrs. Chester I. Ulmer, Gloucester; Mrs. B. W. Howley, Middlesex.

The slate was approved.

Publicity.—Mrs. O. R. Carlander, Chairman, sent a report stating that reports and responses from the various Auxiliary branches had been exceptionally fine. Reports of the Executive Board meetings had been sent to the various papers, and requests were extended to the members reading these articles to clip them and send to the Publicity Chairman for filing. Reports had also been sent to the National Chairman of Press and Publicity.

Public Relations.—Mrs. Lippincott, Chairman, reported that the physicians did not want the list of "Speakers' Bureau" given to the lay people, because they would have a tendency to pick their own particular speaker and make the contact without appealing to the Auxiliary. It was suggested that the laity be informed that speakers could be had on certain subjects listed, but that they could also be supplied for any subject desired.

Treasurer.—Mrs. Thomas B. McConaghy reported a bank balance of $533.71. Letters are to be sent to the counties asking for contributions for the Annual Meeting Fund, and for the National Meeting Fund. Delegates' and alternates' cards will be sent at the same time.

Arrangements.—Mrs. J. H. Hornberger, Chairman, had been ill. Mrs. Don A. Epler made the arrangements for the luncheon at the Essex House, and for the guest speaker for the afternoon, Dr. LeRoy A. Wilkes, who was also to be the guest of the Auxiliary for luncheon.

Public Health.—Chairman Mrs. H. Roy Van Ness had sent out questionnaires to each County Auxiliary, asking what had been done in the country. She explained the five-minute health talks, and asked that they be returned as soon as possible, in order that they might be sent to other Auxiliaries. She suggested that there be a conference held at the Annual Meeting, of the County Public Health Chairman, together with the Public Relations Chairman, to discuss what had been done, and what might be done throughout the State. She also suggested that the name be changed to read "Program —(Health Education)", thus conforming to the national name.

She also asked that the News Letter from National be sent to the Chairman of Public Health.

Mrs. Van Ness asked that at each meeting of the County Auxiliaries ,some article of the moment be read; that if the counties approved, she would send such articles to them.

As a member of the Public Health Committee of the State of New Jersey, she had contacted Contemporary Club of Newark, offering them the following:

1. Speaker.
2. Round-table discussions lead by a physician.
3. Reports in the form of five-minute talks.
4. Lessons in First Aid, Home Nursing, and a course for expectant mothers.

The Contemporary was very much interested, and was anxious to coöperate. She has also been asked to write an article for "Contemporary Life", which will appear in the April issue. The Red Cross has not been successful in putting this program across, but since this start has been made, it may be possible to place this activity where it belongs later.

Widows' and Orphans' Society.—Mrs. Theodore Teimer, Chairman, reported that the work had been more discouraging this year than ever before, that only one subscriber had been added to the list, and that from Essex County.

Organization.—Mrs. Don A. Epler, Chairman, had sent out a questionnaire, urging the counties to answer it promptly.

Constitution and By-Laws.—Mrs. Frederick Kinch, Chairman, presented the changes which had previously been mailed to each member of the Board.

Addition to Constitution, Article VI, Officers—

"They shall assume office at the close of the Annual Meeting of each year."

Addition to the By-Laws, Section 2—

"Or until their successors are duly elected and assume office."

It was regularly moved, seconded and carried that this report be accepted.

The calendar which Mrs. Rogers had compiled was discussed very favorably, Mrs. Epler suggesting that it might be made a permanent feature.

SPECIAL AUXILIARY PROGRAMS TO WHICH ALL THE MEMBERS ARE INVITED

A Public Relations Tea, Union County Auxiliary, at the home of Dr. and Mrs. Frederick Kinch, Westfield. Speaker: Dr. Henry C. Barkhorn, on the "Cause and Cure of Deafness"; the date, March 23rd at three o'clock.

A Public Relations Tea, by the Burlington County Auxiliary, at the Moorestown Community House, May fourth.

Reciprocity Tea, by the Atlantic County Auxiliary, at the Women's Club in Atlantic City, March thirtieth, at 2:30 p. m. Speaker: Dr. Cole Davis. Guest of honor, Mrs. George A. Rogers.

Passaic County Auxiliary is conducting a meeting at the Woman's Club in Paterson, March fifteenth, at 3:30 p.m. Guest speaker: Dr. Foster Kennedy, who subject is "Nerves".

Essex County Auxiliary is holding a meeting at the Academy of Medicine in Newark, March fourth, at three p.m. Subject for discussion, "Venereal Diseases".

Burlington County Auxiliary is sponsoring a meeting at the Town Hall in Mt. Holly, March eighth, When Dr. Jones of the Colony at New Lisbon will speak on the subject of "The Underprivileged Child".

Mercer County is sponsoring a social tea and meeting, during which time Governor Hoffman and a member from the Executive Office of the State Society will speak. This to be held at the Contemporary Club in Trenton, March eleventh, from two to five.

COMMUNICATIONS

Andrew Krog, of the Department of Health, City of Plainfield, asked that we push a bill which had passed the Assembly, which gives the Public Health Department control over public swimming pools and baths.

A letter from the New Jersey Health and Sanitary Association welcomed the Auxiliary into its association, and explained some of the topics in which it was interesting itself. It was suggested that the name of the Legislative Chairman be sent to this association, in order that she might be notified of any bills which would affect the activites of the organization; and also of time and place of the association's meetings.

It was decided that the name of the Corresponding Secretary be sent, she in turn to notify the Public Relations Chairmen of the counties in which meetings were to be held.

Mrs. McConaghy was instructed to send to the State Federation of Women's Clubs the "Blue Blank" properly filled in, in order that our Auxiliary might be sent notifications.

The Recording Secretary was appointed Federation Secretary, and was instructed to write for information as to what privileges the Auxiliary is entitled.

The members were again urged to check on whether or not the Reading Lists had been posted in the various libraries.

Mrs. Surran gave an extensive report on the arrangements for the Annual Meeting.

The meeting was adjourned for luncheon at one o'clock. Much credit is due Mrs. Don Epler for the delicious luncheon, which was, according to all comments, greatly appreciated and relished.

At two o'clock the meeting reconvened, when the President introduced the guest speaker, Dr. Wilkes, who explained some of the aims of the State Medical Society; the background of its program; and a short history of a physician's training, all of which tended toward a clearer understanding of the work in which the Auxiliary might interest itself.

Among the interesting statements made were: The Social Security Plans and Programs, formulated by New Jersey, are being offered to other states; that the Welfare Committee is divided into four important parts, of which the Public Relations Committee is one; the Welfare Committee is unique in New Jersey, in that it has representation from every component society in the State; that the four main committees have sub-committees; that in the past, due to lack of organization, the Welfare Committee has had to talk too much from "opinion", but that now it was gathering facts, recording them for future use, with explanations.

In view of all of these activities, the immense amount of work, and the need for money to carry it out, Dr. Wilkes asked that we might be a help in interpreting to the physician why his dues may be increased; that the program planned cannot be carried on with the present dues; that there is a place for the Auxiliary, in organizing, both in its own and in other groups; that the Auxiliary should give suggestions to the Executive Office for help in the plans of the Society. He also informed us that there are pamphlets on Social Medicine which can be procured by writing to the Executive.

NATIONAL AUXILIARY

Mrs. Surran, Chairman on Arrangements for the National Meeting stated that she had consulted Mrs. Fitzgerald of the National Auxiliary about convention funds; that Mrs. Fitzgerald had suggested that there be a Local Convention Treasurer, that this had been customary; and on that suggestion, she had appointed such a Treasurer, but that the request for money from the State Medical Society had been sent through Mrs. Rogers to the Treasurer of the State Medical Society.

Mrs. Salasin read a résumé of the sums of money needed early, by Mrs. Surran, based on what was used at the last National Meeting held in Atlantic City. This amount totaled $663.71.

Mrs. Stillwell moved that the Convention Treasurer be insured for two months, the fee being $7.50. This was seconded and carried.

A motion was made, seconded and carried that the name "Chairman of Public Health" be changed to read "Chairman of Program".

Mrs. Rogers announced that, if possible, she would call a meeting of the County Chairmen of Public Health and of Program at the next Annual Meeting.

The Delegates and Alternates to the National Auxiliary were selected as follows:

Delegates	*Alternates*
Mrs. George A. Rogers	Mrs. F. G. Shaul
Mrs. A. H. Lippincott	Mrs. D. C. Reyner
Mrs. H. B. Hubbard	Mrs. Theodore Teimer
Mrs. Don A. Epler	Mrs. H. Roy Van Ness
Mrs. F. A. Kinch	Mrs. J. H. Hornberger
Mrs. F. B. Gilpin	Mrs. James McGuire
Mrs. A. E. Jaffin	Mrs. G. E. McDonnel
Mrs. T. P. McConaghy	Mrs. W. A. Freile

A motion was made, seconded and carried that the Treasurer's bond be renewed for the coming year.

Mrs. Kinch moved that the State contribute the sum of $200.00 for the National Meeting Fund, with the understanding that if there is a deficit, the counties be asked to make it up. This was seconded and carried.

Mrs. Rogers announced that she would ask Phila-

delphia County and the State Auxiliary of Delaware for contributions for the National Meeting Fund.

Mrs. Casselman informed the County Auxiliaries that President's pins could be purchased at Bailey, Banks and Biddle's for $6.00.

The meeting adjourned to convene in Atlantic City in April.

Respectfully submitted,

Clara C. Renner,
Recording Secretary.

COUNTY SOCIETY REPORTS

Atlantic County

Reported by Mrs. L. M. Walker,
Chairman of Publicity

The regular monthly meeting of the *Auxiliary to the Atlantic County Medical Society* was held Friday evening, March 12th, at the Ambassador Hotel.

At the conclusion of the business meeting, Mrs. G. Ruffin Stamps gave a very comprehensive review of Dr. V. Heiser's "An American Doctor's Odyssey". It was voted to buy a copy of this excellent book and present it to the Atlantic City Library in memory of Dr. E. H. Harvey.

Mr. Lawrence Swan, Field Representative for the New Jersey Housing Administration, spoke on "The Story of the National Housing Act". Mr. Swan explained that while this project was new in this country, it had first proven its worth in England and Finland, and that it was inaugurated to correct the low estate into which housing had fallen during the depression. He stated that the F. H. A. is an insurance program, and a permanent contribution to our country.

Plans were made for a Reciprocity Tea to be given on March 30th, 1937, at two o'clock, at the Women's Club, Crillon Hotel, Indiana Avenue, Atlantic City. This has become an annual event and is attended by the local women's clubs; and is for the purpose of getting acquainted socially and with each other's various charitable and civic activities. Members of the Auxiliary will act as hostesses. Mrs. Alfred Westney is arranging an interesting musical program, and Dr. Cole Davis will be guest speaker for the afternoon.

Members of the Program Committee for the State Convention, which will hold a three-day session in the resort April 27-29, will meet at the Hotel Madison on March 30th, at 10 a. m. At that time plans will be perfected for entertainment of out-of-town and local members of the State and County Auxiliaries.

Present were: Mrs. John L. Massey, Mrs. Samuel L. Winn, Mrs. James MacFarland, Mrs. E. G. Shreve, Mrs. Marion L. MacNab, Mrs. Blair Stewart, Mrs. Alfred Westney, Mrs. William W. Hersohn, Mrs. Ily R. Beir, Mrs. David B. Allman, Mrs. Harry Subin, Mrs. Louis Feinstein, Mrs. A. Merendino, Mrs. D. Reyner, Mrs. Percy Clark Joy, Mrs. Carl A. Surran, Mrs. Lawrence A. Wilson, Mrs. Allan Rieck, Mrs. Herman Kline, Mrs. Morton M. Major, Mrs. George A. Poland, Mrs. Myrtile Frank, Mrs. E. Harrison Nickman, Mrs. Manuel J. Mally, Mrs. Charles Hyman, Mrs. G. Ruffin Stamps, Mrs. E. L. Shore, Mr. and Mrs. Lawrence Swan, Mrs. Peter Marvel and Mrs. L. M. Walker.

Burlington County

Reported by Mrs. Roscius I. Downs

A social evening of the *Auxiliary to the Burlington County Medical Society* was held at the home of Mrs. Joseph Kuder, of Mount Holly, on Tuesday, March 2nd, 1937. Dainty refreshments were served.

The President, Mrs. Dean H. Le Favor, of Palmyra, conducted a brief business meeting.

The following Nominating Committee was appointed:

Chairman, Mrs. J. H. Hornberger, Roebling
Mrs. Milton Schisler, Florence
R. D. Geary, Riverside

A favorable report was received regarding our pupil nurse in Burlington County Hospital. Her work is satisfactory and her examination marks are high.

Mrs. Howard Curtis, of Moorestown, and Mrs. F. D. Fahrenbruch, of Mount Holly, will solicit needs of the Burlington County Hospital and choose a worthy cause in which to invest our hospital fund surplus.

Mrs. G. E. McDonnell, of Mount Holly, is Chairman of our Public Relations Tea which will be held in Moorestown on Tuesday, May 4th.

We plan to send a delegation to the Mercer County Tea at Trenton on March 11.

We are giving a movie benefit at Criterion Theatre, Moorestown, on April 5th and 6th,—entitled "Lloyds of London". The proceeds will go into the hospital fund.

Mrs. LeFavor will hold an Executive Board meeting at her home in Palmyra on March 22nd, to plan the program for the rest of the year. The delegates to the State Convention will be appointed at that time.

Members present: Mrs. D. H. Le Favor and Mrs. H. P. Landis, of Palmyra; Mrs. D. H. Ulmer, Mrs. Howard Curtis, and Mrs. T. J. Summey, of Moorestown; Mrs. F. D. Fahrenbruch and Mrs. Joseph Kuder, of Mount Holly; Mrs. W. B. Bray and Mrs. L. B. Hollingshead, of Pemberton; Mrs. Milton Schisler, Mrs. Walter Zwick, Mrs. R. D. Geary, and Mrs. R. I. Downs, of Riverside.

Camden County

Reported by Mrs. George B. German,
Chairman of Publicity

It is with deep and sincere regret that the *Woman's Auxiliary to the Camden County Medical Society* announces the death of one of Camden County's most prominent physicians, who was held in high esteem and affection by all who had the privilege of knowing him. Dr. A. Haines Lippincott, husband of Mrs. Mirlam Lee Early Lippincott, a Past President of the Camden County Auxiliary, passed away on Wednesday, March 10th, 1937.

On Tuesday, March 2nd, the regular meeting of the Auxiliary was held in the form of a Public Relations Tea at the Women's Club in Camden. The subject of the day was Cancer Control. Six

of the doctors belonging to the Medical Society spoke: Dr. Joseph Roberts on x-ray; Dr. Thomas B. Lee on gynecology; Dr. Henry Decker on skin cancer; Dr. Wright on genito-urinary tract; Dr. Reubin Sharp on intestinal tract; and Dr. Evans on oral surgery.

Our honor guest was Mrs. Alfred Gray, President of the Auxiliary of Lankenau Hospital Research Laboratory of Philadelphia.

The amendments to the Constitution were passed.

On Monday evening, March 8th, the Auxiliary, with Mrs. J. Wesley Jack as general chairman, sponsored a very successful fashion show and card party in the Walt Whitman Hotel, Camden. Three hundred and fifty dollars were realized, most of which is to benefit the Camden County Tuberculosis Association.

Essex County

Mrs. Frank S. Forte, Reporter

The Public Health and Public Relations Committees are endeavoring to become affiliated with the Contemporary Club of Newark in sponsoring health projects. The committees are also negotiating for an informal tea to be given at the Academy of Medicine in the near future for the Presidents, Secretaries, etc., from various organizations interested in health work. The speaker will be provided from the Medical Speakers' Bureau, in order to explain the purpose of the Bureau and to have it become known throughout Essex County.

The committees are also planning to have a skit on the radio about the Speakers' Bureau.

A combined luncheon and meeting of the Auxiliary was held on February 18th, Mrs. Joseph Swirsky and Mrs. Harry A. Schacter, presiding.

The monthly meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held Tuesday, February 23rd, at the Academy of Medicine. E. W. Garrett, Deputy Commissioner of the Department of Alcoholic Beverage Control, was guest speaker.

A Cheer Committee was organized to send cards, flowers, etc., to sick members, at the discretion of the Chairman, Mrs. William D. Minningham.

Letters were sent to thirty-three women physicians advising them that they are honorary members of the Auxiliary.

Mrs. Don Epler is arranging a card party to be held March 16th, at the Essex House, to buy coffee urns for the Auxiliary.

Doctors' wives will serve as hostesses for the annual meeting of the doctors at the Academy of Medicine. Mrs. Don Epler is chairman of the hostesses' meeting to be held March 18th.

Gloucester County

Mrs. Fuller Sherman, Reporter

The *Gloucester County Auxiliary* held its regular monthly meeting on Thursday evening, March 18th, at the Homestead Coffee Shop. Mrs. A. B. Black and Mrs. Fred Wandall were the social committee for the evening. Following the meeting the ladies joined the doctors for supper.

Hudson County

Reported by Mrs. James Murphy

The regular monthly meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held March 1st, 1937, at the Y. W. C. A. in Jersey City. Mrs. A. E. Jaffin, the President, presided and there were thirty-six members present.

Since our last meeting, Mrs. John H. O'Neil, one of our faithful members, passed away. A very beautiful eulogy was read by Mrs. George Culver.

The Chairman of Public Health, Mrs. Benjamin Macchia, had made engagements for Dr. Irwin Markowitz to speak to five organizations on "Social Diseases". Three new organizations had requested the five-minute papers on health topics for reading at their meetings.

Mrs. Jaffin outlined the entertainment program for the Atlantic City Convention April 27-29, and several members agreed to aid her on the Credentials Committee at that time.

Two new members were welcomed,—Mrs. Manuel Hernandez, and Mrs. Dominick Matturri, of Jersey City.

Dr. Earl Fuller, psychiatrist at the Greystone Mental Hospital and at the Jersey City Psychiatric Clinic, was the speaker for the afternoon. He said that all doctors should be psychiatrists, as the human system must be dealt with as a whole. The psychiatrist finds in the child patterns of conduct that are copied from the speech, emotional reactions, and codes of those with whom he is associated. These patterns learned in childhood may lie dormant for years, and appear in adult life in unusual reactions. Dr. Fuller told of individual cases which vividly portrayed these patterns in conduct. He spoke also of physical difficulties that covered the mental life of patients under his care and observation. He was very successful in illustrating the reasons behind the manifestations of mental ill health.

The annual card party, to which our members and friends look forward, is to be held March 31st. Tea was served at the conclusion of the meeting, with Mrs. Bernard Kelly as hostess.

Mercer County

Mrs. L. Leonard Friedman, Reporter

The *Woman's Auxiliary to the Mercer County Medical Society* held a Public Relations Tea on Thursday afternoon, March 11th, at the Contemporary Clubhouse. Invitations were extended to Mercer County P.-T. A., Mercer Hospital Aids, The Contemporary Club, Mercer County Health League, officers of Woman's Medical Auxiliary of New Jersey and various Trenton women's organizations.

Mrs. C. Chester Chianese, President of our Auxiliary, assisted Mrs. Alton S. Fell, Chairman of Public Relations Committee, with plans and arrangements for the affair.

Mrs. Charles F. Adams and Mrs. George N. J. Sommer presided at the tea table. Hostesses included Mrs. Alvin W. Atkinson, Mrs. Dunbar A. Hutchinson, Mrs. James J. McGuire and Mrs. Robert G. Stone.

Mrs. William C. Ivins was Chairman of the Reception Committee. Assisting were Mrs. William J. Abey, Mrs. Ralph J. Bedford, Mrs. Ed. W. Burroughs, Mrs. H. Don Cowlbeck, Mrs. Charles

E. Clark, Mrs. George Corio, Mrs. P. H. Corrigan, Mrs. Walter E. D'Arcy, Mrs. Elmer J. Elias, Mrs. D. Leo Haggerty, Mrs. James R. Harman, Mrs. Ed. K. Hawke, Mrs. Frank A. McGuigan, Mrs. Albert Moriconi, Mrs. Louis A. Stein, Mrs. L. Samuel Sica, Mrs. Peter J. Warter and Mrs. LeRoy A. Wilkes.

Mrs. Fell opened the program of speakers.

Mrs. George A. Rogers, our gracious State President, urged us on most kindly in behalf of New Jersey Medical Auxiliaries.

Dr. Joseph H. Kler, State Chairman of Public Relations, gave a diligent talk concerning the purpose and excellent results that come from these meetings in promoting a better understanding between the medical profession and laity.

Mrs. Fred A. Kinch spoke a few words of greeting.

Mr. Carl A. Daines, Supervisor of Social Hygiene Education in the New Jersey State Department of Health, gave an interesting discussion on venereal disease.

The President of the P.-T. A., Mrs. Houseley, was introduced.

Mrs. C. Chester Chianese, our President, was in charge of the entertainment program.

Charlotte Rulon, a talented pianist, rendered "Valse in A" by Levitski. Robert V. Jannelli, an artist of reputation, played a beautiful flute solo, "Pastorale Fantasie", by Doppler. Winnie W. Herbert, a real actress, added a colorful touch with some of her best characterizations.

Dr. LeRoy Wilkes presented our honored guest, Governor Hoffman. The Governor paid glowing tribute to the activities of doctors' wives in behalf of the medical profession of New Jersey. He deplored the lack of patriotism in boosting of our State, which is rich in natural resources and fine properties. He said that New Jersey people had everything to be proud of, and that we should be more outspoken in its praise. He related humorous stories and pathetic scenes to bring out more clearly his points. The biggest problem just now that needs his utmost consideration is the unemployment question—to help the really indigent.

The Governor concluded his speech by reassuring us that inasmuch as we are all an auxiliary, we all merit worthy laudation. The Governor has a convincing, genuine personality and delighted us by joining us at tea. A most enjoyable social hour followed, tea being served by our charming committee. This affair was a great success. Representatives from different parts of the State were in attendance. Much enthusiasm was shown by our large audience.

Passaic County

Reported by Mrs. Florence C. McCarthy

The *Woman's Auxiliary to the Passaic County Medical Society* held an open meeting on the afternoon of March 15th, in the Passaic Y. W. C. A. Building, with the President, Mrs. L. R. Taber, presiding.

Reports were heard from Mrs. J. E. Mott, Mrs. J. Delario, and Mrs. Nicholas Scielzo, after which refreshments were served by Mrs. L. Coen.

Mrs. J. S. Gallo, Mrs. Roy Shubert and Mrs. Bertram Koenig were welcomed as new members.

The guest speaker, Dr. Foster Kennedy, Professor of Neurology at the Cornell Medical School, was introduced by Mrs. Richard McDonald, Program Chairman.

Dr. Kennedy traced the origin of man anthropologically, showing the gradual development of the human brain. He pointed out that new patterns are constantly being superimposed on old ones, and stated that in disease the old ones become dominant when the new ones are swept away. Dr. Kennedy also traced the functions of glands and their importance to the human body.

Union County

Reported by Mrs. Helen M. Murphy

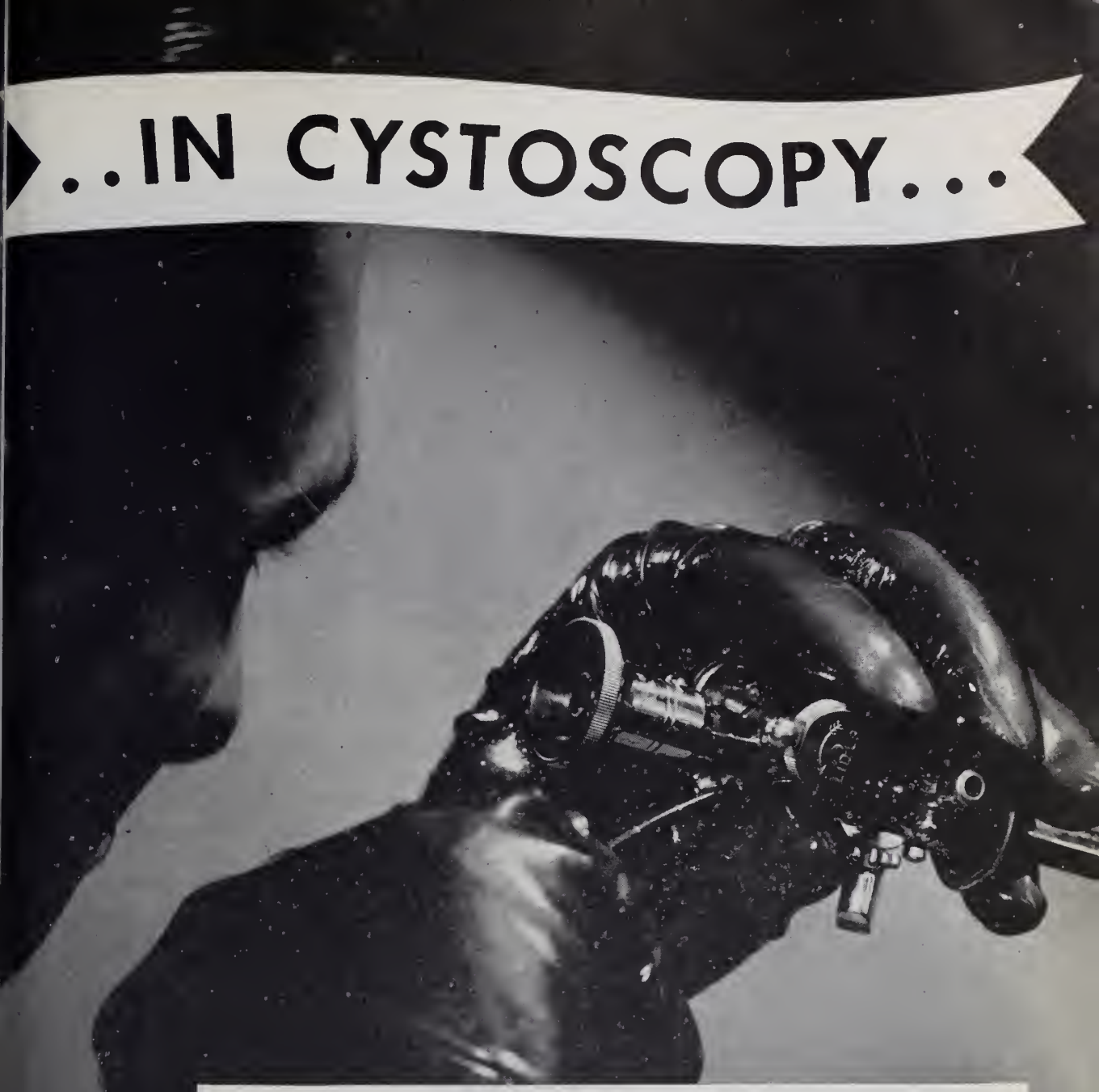
The regular meeting of the *Woman's Auxiliary to the Union County Medical Society* was held at the home of Dr. and Mrs. C. H. Schlichter, of Elizabeth, Wednesday evening, February 10th. The slate for the coming year was presented by the Nominating Committee and the Delegates and Alternates to the Atlantic City Conventoin in April were appointed.

Following the business meeting, Mrs. F. B. Gilpin, President, introduced the speaker, Dr. J. B. Morrison, Secretary of The Medical Society of New Jersey, who spoke on the subject of State Medicine, pointing out its disadvantages. He showed how poorly it worked in England and what it would mean to the layman as well as the doctor in the United States if it were adopted here. The status of medicine would definitely be lowered.

Refreshments were served by the hostess assisted by Mrs. W. J. Hallock, Summit; Mrs. G. A. Seymour, Elizabeth; and Mrs. H. S. Murphy, Roselle.

At a tea at the home of Dr. and Mrs. F. A. Kinch, in Westfield, on March 23, Dr. Henry C. Barkhorn, of Newark, addressed the Auxiliary on the "Cause and Cure of Deafness".

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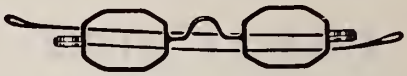
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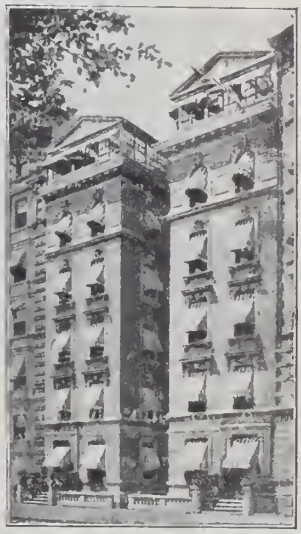
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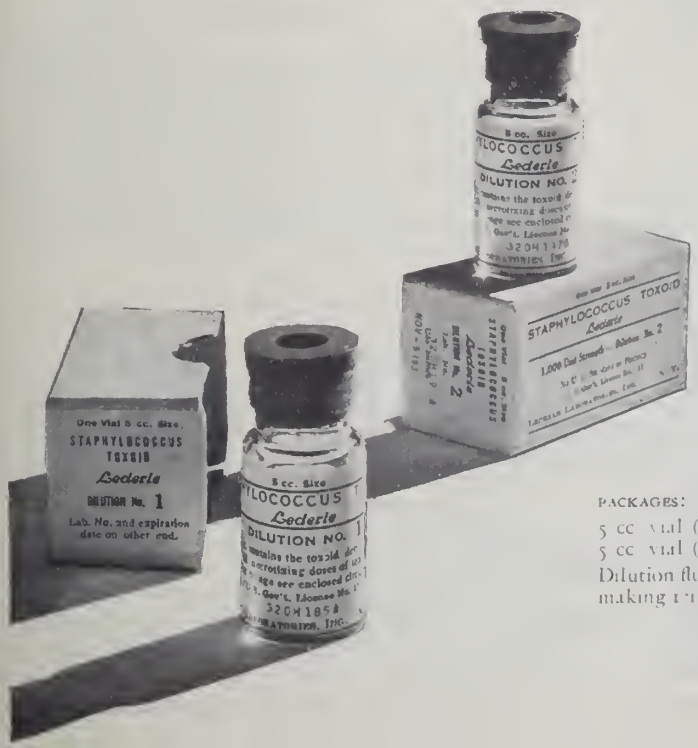
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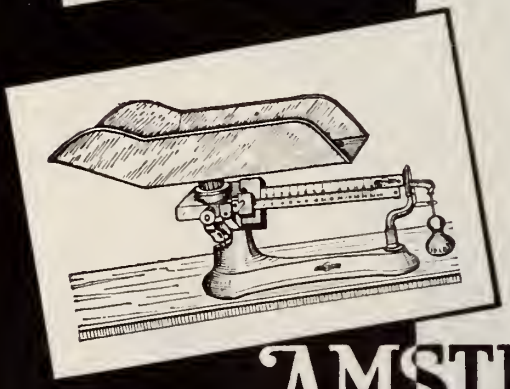
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VITAMIN REQUIREMENTS OF MAN

III. VITAMIN A

● The importance and multiple functions of vitamin A in human nutrition are widely dealt with in clinical literature. Xerophthalmia resulting from severe vitamin A deficiency is rare in this country, yet the etiology of many pathogenic conditions, namely, night-blindness, urinary calculi, lesions of the nervous system, impairment of epithelial tissue and subnormal growth, has been linked with chronic avitaminosis A (1).

Minimum human requirements for vitamin A are influenced by such variables as size of the individual and efficiency of absorption. The minimum daily requirement of infants has been estimated at 1500 International units, based upon the vitamin A content of milk. The need for the vitamin is not supplied by 1200 International units, while 2000 International units appear to be sufficient (2).

Although the minimum requirement of the adult has been estimated to be as low as 500 International units, the optimum level for both older children and adults is probably between 3000 and 5000 International units per day (3). The League of Nations Technical Commission recommends over 5000 International units of vitamin A for the pregnant and for the lactating woman (4).

Since the human requirement is evidently high, it is fortunate that vitamin A and carotene (pro-vitamin A) are more or less widely distributed in natural foods. Outstanding sources are some of the highly pigmented fruits and vegetables—especially the yellow varieties—and also dairy and marine products (5).

These protective foods, preserved by modern commercial canning, are readily available in all parts of the country throughout the year. It has been repeatedly demonstrated that commercially canned foods retain their vitamin A potency to a high degree (6). The vitamin A potencies of certain commercially canned products have been recently reported in International units (7). From these reports it is apparent that commercially canned foods can be relied upon to supply quantities of vitamin A entirely consistent with the vitamin A of the raw product.

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(1) a. 1935. J. Am. Med. Asso. 105, 1608
b. 1936. Ibid. 106, 996
(2) 1934-35. Am. Pub. Health Asso. Year Book, Page 70.
(3) a. 1934. J. Am. Diet. Assn. 10, 296
b. 1936. Iodian J. Med. Research 23, 741
(4) 1936. League of Nations Report on Physiological Bases of Nutrition, League of Nations Publication Department, Geneva.
(5) 1933. Chemistry of Food and Nutrition. H. C. Sherman. 4th Ed. Page 364. MacMillan. New York.
(6) a. 1931. J. Nutrition 4, 267
b. 1933. J. Am. Diet. Assn. 9, 295
c. 1936. J. Nutrition 11, 383
(7) a. 1935. J. Home Econ. 27, 658
b. 1933. Georgia Expt. Sta. Bull. No. 177
c. 1936. J. Am. Diet. Assn. 12, 231

This is the twenty-fourth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



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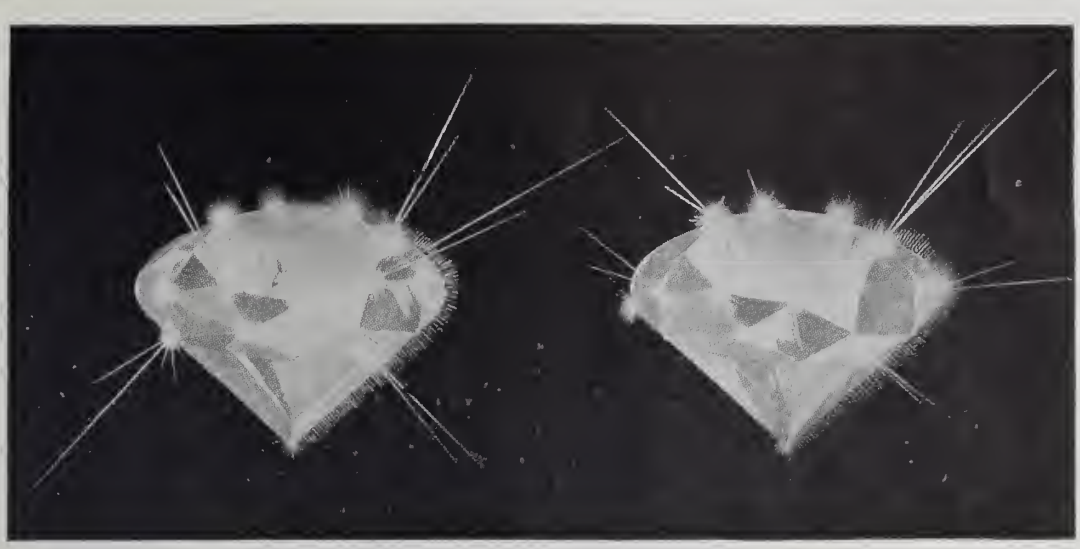
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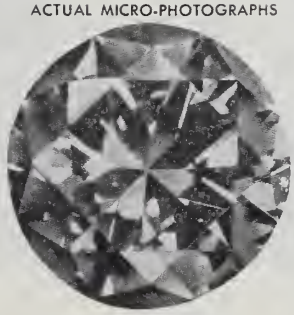
Two diamonds, side by side . . . each has dazzling brilliance. To the average purchaser they seem identical. But only one is perfect; the other's value is far less because of carbon flaws. Yet only an expert can detect the difference.

The ordinary purchaser has no way to tell a fully potent vitamin product from a deficient one, either. They may look alike . . . weigh, taste and smell the same. Only an expert with elaborate equipment can measure true vitamin content.

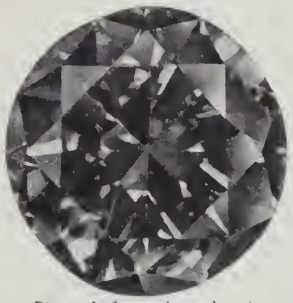
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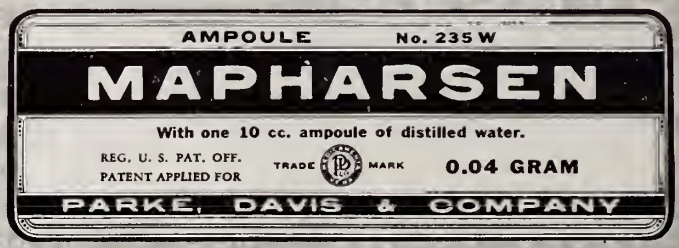
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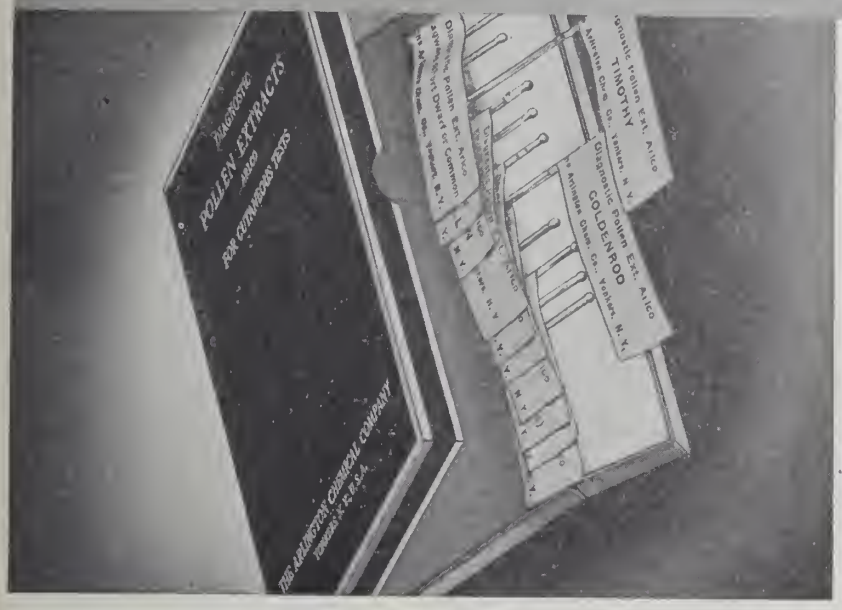
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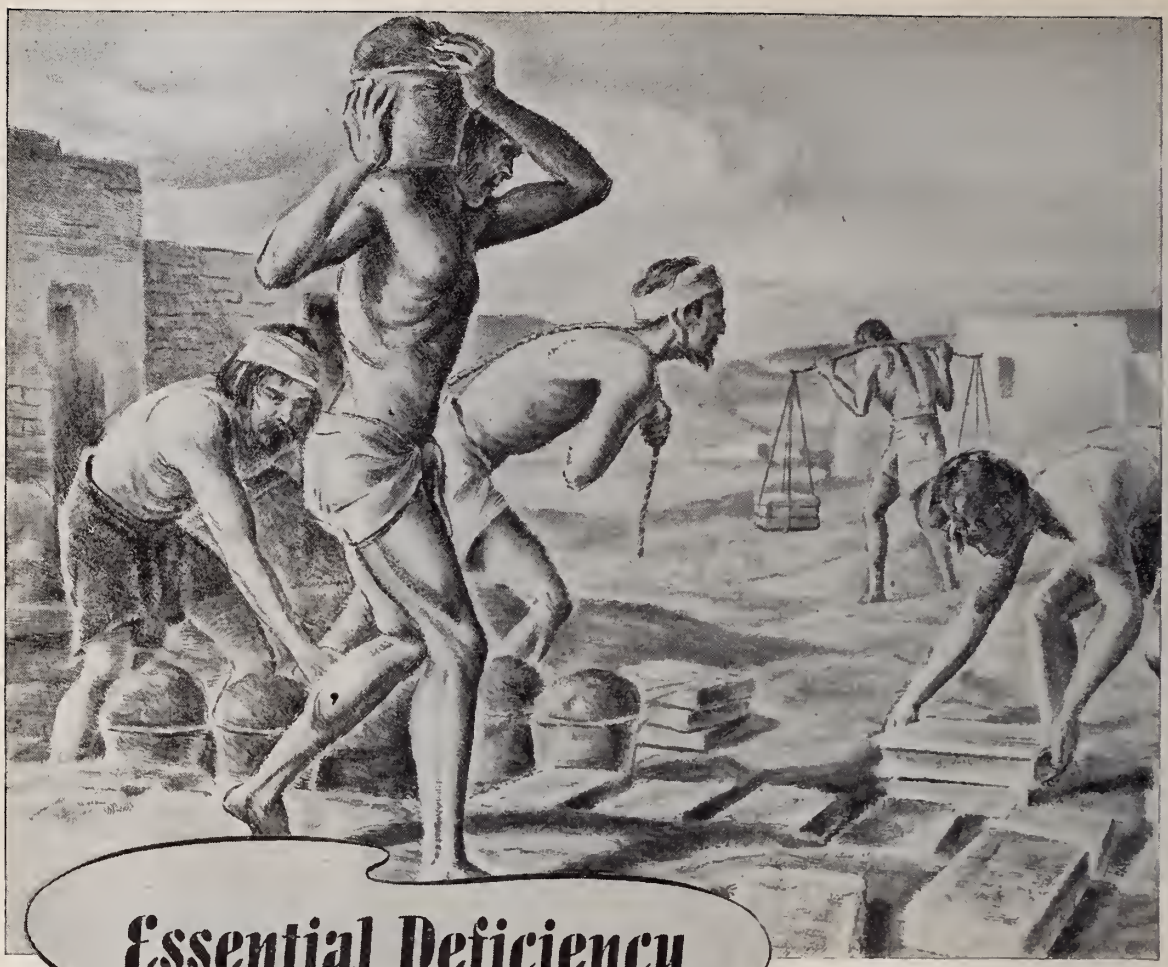
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Volume XXXIV.
Number 5

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly

Under the
Direction of the
Committee on Publication

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Frank Overton, M.D., Dr. P.H.

Editorial and Executive Offices of the Society
143 East State Street, Trenton, N. J., Tel. 9330
Executive Officer—LeRoy A. Wilkes, M.D.
Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. XXXIV, No. 5 May, 1937 Subscription, $3.00 per Year
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EDITORIALS

The Annual Meeting of 1937

The Annual Meeting is the culminating activity of The Medical Society of New Jersey during the year, and few members realize the immense amount of time and effort which is put into its preparation and execution. It has a dual purpose,—first to review and summarize all phases of its work; and second to develop and approve plans for the coming year. Up to very recent years the preparation of the annual reports has been the uncoördinated effort of each officer and committee; but this year the principal annual reports were prepared early, and were submitted to the Welfare Committee which held two meetings for their consideration. The approved reports were edited and proof-read,—sixty pages of The Journal, or twice the usual amount of space, were utilized in their printing.

The reports were then distributed to six reference committees for study and approval of their suggestions. The individual members of the reference committees not only devoted two weeks to their consideration, but they also held meetings during the annual session, and heard the arguments of any physician who asked for information or had suggestions to make. The final reports of the Reference Committees were made during the last session of the House of Delegates, and were considered by the entire House. The whole series of studies had been so thorough and complete that almost every report was adopted unanimously.

Every annual report had therefore been carefully reviewed by three unbiased groups:

1. The Welfare Committee.
2. The Reference Committee.
3. The entire membership of the House of Delegates.

Every report had received the careful attention of over two hundred members, who represented a cross-section of the entire membership of the State Society. The final actions taken by the House of Delegates were a cross-section of the opinions of the individual members and of the county societies.

The prospects for the coming year are most encouraging. The past few administrations have fostered a spirit of teamwork in which a powerful influence radiates in widening circles from the State Society, to the county societies, to the individual members, and to the people generally. There is every prospect that there will be a great increase in the return flow of influence and the response of the people, the members, and the county societies.

Priestly Office of the Physician

Six days it took the Lord to make the earth
A fit abode for man, and to create
A human soul to whom by Godly birth
Was given power divine to dominate
The whole created Universe if he
Should be obedient to that heavenly Voice
Which tells the sons of men unerringly
Between the good and bad to make their choice.
His first day's work, to light the glowing sun;
His last, to illuminate the human mind.
To carry on the work then well begun
Is yet the task of those who love mankind,
Divinely chosen to be priests of Him
Who heals both soul and body by His grace,
And fills our cup of mercy to the brim
And keeps us in the image of His face.

To each physician comes the priestly call
To give relief from every evil plaint.
And his abode is a confessor's stall
Where congregate the sinner and the saint,
Prepared to do hard penace to atone
For sin confessed and absolution sought
With many a prayer, and contrite tear, and groan,
Believing quick forgiveness can be bought
From one whose miracle-performing power
Attests him as the anointed one who holds
The keys of death and life until that hour
When to ripe years the sinner's course unfolds.

To some physicians comes the higher gift
Of prophecy that they may timely warn
The sinner of the judgment sure and swift
On those who hold the laws of God in scorn.
With inspired vision they discern afar
The danger signs and urge that men should flee
From wrath to come for mortal sins that mar
Both soul and body through eternity.
But men unheeding pass and fondly cling
To favorite sins committed o'er and o'er,
And then in terror, ask the priest to bring
Forgiveness and the help they scorned before.

A chosen few endowed with gifts to teach
New truths revealed to those with sight refined
Obey the urgent call to go and preach
The gospel of good health to all mankind,
That each frail human body yet may be
An instrument well fitted to perform
The deeds planned through the soul's high ecstacy,
Which to the mold of God's own will conform.

Blest is the priestly doctor comforting
Both soul and body though he fail to heal.
Blest, too, the prophet doctor who can bring
Unwilling sinners in remorse to kneel.
Most blest is he who to a child can show
A vision of rich life abounding bright
With joy and fruitfulness, that it may grow
To man's estate safe led by heavenly light.

—F. O.

Three Annual Meetings in a Year

Three annual meetings were held this year, as in every past year.

First there was the Annual Meeting that was *planned,*—more extensive, more interesting, and more practical than ever before. It was the meeting that we wished it to be—everyone pleased and edified, and inspired. All the imperfections of previous years were corrected. The papers were thrillingly interesting, the business was transacted wisely and promptly, and goodfellowship prevailed.

Second was the three-day meeting that was *actually held.* The executive officers, who planned the convention, saw only a small part of it, for they were too busy with details to see it as a whole. Each member who was present chose those features which interested him, and therefore the collective reaction of the members was one of satisfaction, which was enhanced by the fact that if he was not suited with an event, he could leave and choose another more suited to his preferences.

The third meeting is that which exists in *memory,* and of which one reads in the Journal and in future Journals throughout the year. The events will also live in the meetings of officers and committees through the coming months, for their members will carry on the projects which have been approved at the Annual Meeting.

Of the three meetings the third is the most important, for the first two will soon fade from memory; but the influence of the last one will live on in the work of the officers and committees.

But do not belittle the first two meetings for they are the grandfather and the father of the third; and the last one has the spirit and characteristics of those who inspired the plans, and carried them out with good judgment and energy.

Already the Annual Meeting of 1938 is under development, for it is evolving itself out of the fruits of the one which has just closed.

Presidential Greetings

By William G. Herrman, M.D., F.A.C.R., Asbury Park, N. J.

"Boil and bubble, toil and trouble." The witch's cauldron again is brewing. International hatreds, jealousies and greed are causing trade and currency wars accentuating an armament race. We open the morning paper with trepidation lest we find headlines announcing another Sarajevo. At home dust bowls, droughts and floods, unemployment, inflations and sit-down strikes contribute to stir up social unrest.

It would be strange, indeed, if the practice of medicine were left untouched, while other phases of life are deeply affected by the present social unrest. Medical education grows longer and more expensive. Scientific medicine grows more costly to deliver in materials and services. The number grows larger who cannot pay for modern treatment. How, then, shall services to the indigent and those at the subsistence level be provided by either the physician or hospital on a basis equitable to all concerned? With the shrinkage of private philanthropy, how can many of our institutions continue to give the highest type of service at less than cost? If they cannot, shall they, therefore, be allowed to practice corporate medicine? What shall be the proper relationship of hospital staffs and boards of managers in the determination of hospital policies? How far can we go in enlarging public health activities, without relinquishing our time-honored policy of asking fees according to the economic level? These and many other pressing problems crowd our minds.

There is no immediate answer to any of these questions. Some will have to be solved by the method of trial and error. Many among us have criticized the national organization for not bringing forth a definite answer. Perhaps we fail to realize how diverse are local conditions. What will help in the North or East may be detrimental to the South or West. We think now that most of these problems must be solved in units composed of the various states. We may find that even smaller units than the state will be necessary. The urban and industrial areas face a different situation than the suburban and rural districts. But this appears self-evident, that none of these questions can be solved by us as individuals.



WILLIAM G. HERRMAN, M.D., F.A.C.R.
Inaugurated President April 29, 1937

The past year has been a fruitful and busy one in developing and enlarging our organization. Study has been given to all of the problems facing the medical profession. In the coming year, this study will be continued. Rash solutions must be avoided. Membership must be increased, so that we speak and act for all ethical physicians. All must give increasing loyal support to those who give the time to protect and advance the interests of the profession.

Let us not be discouraged by the depth or complexity of the problems before us. Let us look forward, not backward, and yet seek to preserve the best of yesterday and today as a heritage for tomorrow.

William G. Herrman.

Integration of Medical Effort

The events of the Annual Meeting afford evidence of a steady progress in the integration of the entire medical profession of New Jersey into a coördinated organization.

A fitting text on integration would be the twelfth chapter of First Corinthians, which reads:

"Now there are diversities of gifts, but the same spirit, * * * and there are differences of administration, * * * and diversities of operations. * * * The body is not one member, but many. * * * If the foot shall say, 'Because I am not the hand, I am not of the body', is it therefore not of the body? * * * and if the ear shall say, 'Because I am not of the body', is it therefore not of the body? * * * But now are they many members, yet but one body. * * * The eye cannot say unto the hand, 'I have no need of thee', nor again the head to the feet, 'I have no need of you'. But now are they many members, yet one body. * * * There should be no schism in the body, but that the members should have the same care one for another. And whether one member suffer, all the members suffer with it; or one member be honored, all the members rejoice with it. * * * Covet earnestly the best gifts, and yet I show you a more excellent way."

Then follows the incomparable thirteenth chapter on charity, ending with the well-known verse:

"And now abideth faith, hope, charity, these three; but the greatest of these is charity."

In all the "diversities of gifts and of administration" in the medical profession of New Jersey the same spirit and standard of healing animates every member in the State.

The addresses of Drs. Heyd, Parran, and Howard in the Public Health Session of the Annual Meeting emphasized the fact that differences of opinion among the members of the medical profession do not arise because of varying standards of scientific medicine, but because of the inertia of the social organization of the people. The officers and committees of The Medical Society of New Jersey are earnestly striving to devise plans by which the governmental representatives of the people will supply the means for bringing medical services within the reach of every person.

During the past year the twenty subdivisions of the Welfare Committee have made great progress in integrating the efforts of all groups of people—medical, social, and governmental—into one common purpose, in which practicing physicians shall be the leaders in all things that are directly related to scientific medicine.

A vast amount of coördination of effort is necessary in delivering modern medical service. The small county society cannot say to the metropolitan organization, "We have no need of your elaborate methods"; nor can the great society say, "We scorn your narrow outlook and your 'horse and buggy' ways." But harmony and unity in objectives and methods are rapidly being attained.

The growing unity of the medical profession of New Jersey has been demonstrated in the meetings of the Welfare Committee, which are attended by an average of fifty representatives from every county in the State—large and small, metropolitan and rural, abounding in medical centers and isolated. In all the diversities of abilities, and resources, and temperaments the principle was recognized that there are many roads to any objective; and each county society was encouraged to lay out its own road in its own way, provided it was suited for ready travel toward a common objective, such as reduced maternal mortality, or venereal disease control or graduate education.

Another evidence of the growing unity among New Jersey physicians was the harmony and good feeling that prevailed at the close of the Annual Meeting. The question of a two-dollar-a-year increase in dues threatened to make a division of opinion; but after a full explanation of how the dues are used, the vote for the increase was unanimous.

A third bit of evidence of the growing medical unity in New Jersey is the absence of charges of State Society domination, and the substitution of requests for help. The members throughout the State are recognizing the essential services that are being rendered to them through the central executive offices. The requests vary from those for mimeographing reports for the local officers to looking up information and giving advice regarding troublesome situations. All these services require a diversity of gifts; but they also foster a unity of spirit, and a charity of opinion.

ORIGINAL ARTICLES

A COMPARATIVE ROENTGEN STUDY OF ORAL CHOLECYSTOGRAPHY

By Nathan J. Furst, M.D., Newark, N. J.
Assistant Professor in Roentgenology, New York Post-Graduate Hospital and Columbia University; Director of Roentgenological Department of Newark Beth Israel Hospital
and
Louis J. Gelber, M.D., LL.B., Newark, N. J.
Assistant in Dispensary, New York Post-Graduate Hospital; Assistant Roentgenologist at Newark Beth Israel Hospital.

Read on June 4, 1936, before the Radiological Section of The Medical Society of New Jersey at its 170th Annual Meeting in Atlantic City.

The purpose of this study is to obtain as much information as possible from our various interpretations given to gall-bladder readings extending over the past five years at the Newark Beth Israel Hospital. These Roentgen findings, however, would be of little value were they not checked against the surgical as well as the pathological reports. A good clinical history has been taken in every case. In order to simplify our study we will discuss this subject from several angles:

A. Functionally competent gall-bladder.
B. Functional Disturbance.
   1. Delay in evacuation
   2. Variations in concentration.
C. Pathological gall-bladder.
   1. Failure of Visualization.
   2. Cholelithiasis.
   3. Pericholecystic adhesions.

A. FUNCTIONALLY COMPETENT GALL-BLADDER

In our cases, we observe that with accurate details as to administration of the gall-bladder dye and if given in sufficient quantities, the gall-bladder shadow clearly visualizes in fourteen hours, and begins to show concentration up to the twentieth hour.

To overcome many factors, such as vomiting, misunderstanding, etc., in preventing normal gall-bladder shadows from visualizing in the functionally competent gall-bladder, we employ the double, and sometimes the triple method of administration of the dye. It is surprising how many cases fail to respond on the single administration but are clearly demonstrable on the *second* and *third* examination. This method also checks upon the possible improper ingestion, and intensifies the shadow where a normal gall-bladder exists.

The mode of administration is easily carried out, to wit, if the gall-bladder does not fill after the single ingestion, carefully instruct the patient to eat food rich in carbohydrates, avoiding any containing fat. The food may consist of tea, milk, toast, boiled eggs, etc. Plenty of jello is given. No *cream, butter* or *fats* of any kind are allowed.

At six P. M. the patient is again requested to dissolve the dye in fruit juice or water and to drink all of it. The following day the patient again comes for x-rays after abstaining from all sorts of foods. If the gall-bladder again fails to visualize, we repeat the procedure, being as careful about instructions in the last administration as we were in the first.

With this technic, the patient receives a double or sometimes a triple dose of the dye. We are assured that, if there is non-visualization of the gall-bladder, pathology could only be our possible diagnosis. Whether this pathology is in the form of duct obstruction, malignancy, or chronic cholecystitis can only be judged in each individual case under as careful a technic as possible, together with the *clinical history*.

In view of the fact that errors in oral cholecystography might be due to an uncoöperating patient, or to misinterpretation of the film, yet

the most important factor in reading gall-bladder plates is the technic employed in the administration of the dye. Not only must the dye be given under proper conditions that will not cause nausea or vomiting; but it must be given in a readily absorbable form, and in a quantity sufficient so that visualization will be aided. Some roentgenologists still use the capsules of sodium tetraiodophenolphthalein. Much study of gall-bladder plates with these capsules show relatively poor results as compared with the powder dissolved in a liquid. As early as 1925-6 Levyn and Aaron [1] compared the relative value of different coatings of capsules in regard to their dissolution in gastric and duodenal contents. Their results showed that even though the plain capsules digested readily, a large amount of a white acid form of tetraiodophenolphthalein was formed. This acid radical was insoluble in the duodenal contents. Therefore, they suggested the use of sodium bi-carbonate to be given in these combination capsules in order to do away with the insoluble acid radicals that were formed. Then Fantus [2] came along and he suggested the giving of the gall-bladder dye in a colloidal form which probably would prevent nausea and vomiting. Following this, Sabatini and Milani [3] began to give sodium and strontium bromide by mouth in large doses and this too was found to be unsatisfactory. Therefore, since the possibilities of the breaking up of the mass might be incomplete when the sodium salt is put in a capsule, and in view of the fact that the acid gastric juice might be a deterrent factor in its complete dissolution, the possibility of a better result of the drug dispensed in aqueous solution was considered. Not only must the dye be readily absorbed in the intestinal tract, but its manner of ingestion should be so pleasing that nausea or vomiting would be minimized. This could easily be aided by dissolving the dye in a little grape juice, fruit syrup, or water.

Insofar as experience has taught us that dye given on an empty stomach, even though taken in fruit juice, is liable to cause vomiting or nausea, the giving of a meal containing a minimum of fat immediately before the dye is taken is indeed a simple but important procedure. Any factor interfering with absorption of the dye, and its entrance into and concentration by the gall-bladder, should be avoided. It therefore would be advisable to state at this time that purgatives given during or even before the examination is a procedure to be avoided. Any cleansing that may be desired should be in the form of enemas.

Another factor to be mentioned that interferes with absorption of the dye as well as its concentration is the taking of fatty foods before the examination. The argument that fat in the meal immediately proceeding the gall-bladder might empty it sufficiently so that the dye-laden bile might be easily poured into the gall-bladder, is indeed a mistaken notion. The reason for this is apparent insofar as the fats will stimulate the emptying of the gall-bladder during the time that filling should occur. Besides, it had been shown by Delario [4] that fat renders insoluble a greater amount of the dye in the small bowel.

We, therefore, consider that the technic in oral cholecystography is the most important factor in obtaining good roentgenograms.

The instructions for oral cholecystography at the Newark Beth Israel Hospital are:

1. At 5:30 P. M. have two slices of dried toast and a cup of tea.
2. At 6 P. M. empty the entire contents of the dye into one half glass of water or grape juice, drinking all after stirring well.
3. Do not take any laxatives whatsoever.
4. Do not eat breakfast the following morning. However, weak tea and toast may be allowed. Cholecystograms are then made at the fourteenth and sixteenth hour after the dye is taken.

If the gall-bladder is not visualized at the sixteenth hour, another dose of the dye is given at 6 p. M. During the interval, however, the patient is allowed to eat food free from fat, preferably plenty of jello. When the patient returns the next day and if the gall-bladder is still not visualized, or is faintly visualized, another dose of the dye is given. If nonvisualization of the gall-bladder still exists, the possibility of either duct obstruction or pathology might be the deciding factor.

B. FUNCTIONAL DISTURBANCES

DELAY IN EVACUATION

The most interesting observation consisted in studying the gall-bladder while emptying.

We are familiar with the fact that fats tend to cause rapid evacuation of the gall-bladder. We have observed that after an administration of a fatty meal, the gall-bladder tends to shrink gradually down to 25 per cent of its size over a period of three to four hours. Since several factors might be responsible for this delay in emptying of the dye-laden bile from the gall-bladder, we concentrated our efforts upon finding the causes for this delay. We have accordingly found that where adhesions were involved, delay in evacuation resulted. Since the power of contractility was gone, we were not hesitant in placing this delay in evacuation under heading of "Functional Disturbance".

The emptying of the gall-bladder is accomplished by a change in tonus of the organ, as well as variations in pressure in the hepatic and common ducts. It is probable that the elasticity of the wall of the gall-bladder is a factor in its emptying, and aids in the interchange of the hepatic bile with the contents of the gall-bladder. This, however, depends on the amount of the elastic tissue in the fibro-muscular coat.

This layer not only helps in emptying but also prevents overdistention. When inside pressure within the gall-bladder is relieved, it has properties of elastic recoil. When the gall-bladder is distended, its response to fatty foods is greatest.

Since the gall-bladder reacts to infection very much like tissue elsewhere in the body, any acute infection causes the usual complicated vascular and cellular response. Though perhaps one or several acute inflammatory involvements of the gall-bladder may resolve without leaving a scar, recurrent infections tend to produce a chronic inflammation. This results in an increase of connective tissue, replacing elastic tissue. These changes in the structure of the gall-bladder obviously are likely to produce disturbance of normal physiology. Absorptive activity is early destroyed by injurying the lymphatic and blood supply, and therefore does not permit a normal concentration of the iodized phenophathaleins which are used to produce the shadow after exposures to x-rays. This interference with concentration expresses itself by a decreased density, or no change thereof during various intervals.

Active inflammation or its residue also affects the motility and contractility of the gall-bladder. Shadows of diseased gall-bladders were found by cholecystography not to change in size when the pathological changes in the walls were moderately advanced. This fact indicates that the fibro-muscular layer of the wall had lost its distensibility and contractility.

Why, then do we obtain absorption of the dye and visualization in the gall-bladder in many cases of "delayed evacuation" in view of the fact that chronic cholecystitis exists? This is because the epthelium in the gall-bladder mucosa is never completely destroyed by inflammation. Boyd states, "It is remarkable how intact the epthelium may be in the worst looking gall-bladders." [5]

Alvarez on page 260 of his book "Mechanics of the Digestive Tract" states, "Unfortunately, the value of the Graham-Cole test is lessened by the fact that inflammatory changes in cholecystitis are generally more marked in the outer coats of the gall-bladder than in the mucous membrane."

In order to determine contractility, distensibility, and evacuation, a fatty meal is given after our gall-bladder fills. Tumors and stones often come to light as the gall-bladder empties. Sometimes the patient has to be kept under observation for a period of two days while emptying progresses in cases of prolonged evacuation. Therefore, it is far easier to determine the faintness of the gall-bladder shadow when the double or triple method is given; and in our studies we have found that the faint shadow is rarer with this method than with the former technic of only one dose.

A very interesting observation in the study of our cases showed the great number of times that adhesions were not reported on our x-ray findings. The Graham test may demonstrate a normal gall-bladder shadow of good intensity,

and not even be deformed, although surrounded by a mass of adhesions. The fact that the viscus is held constantly in an unusual position whether the patient is erect, supine, or prone may usually indicate adhesions. Furthermore, our studies point out that where there was delay in evacuation, the possibility of adhesions in the background might be the underlying cause.

One also must not lose fact of the secondary sign of gall-bladder pathology as evidenced by our gastro-intestinal examination. Our percentage of errors in gall-bladder pathology was brought down considerably by checking up on the gastro-intestinal system. In the study of our cases, if we observed that the gall-bladder failed to contract to one-quarter its size in four hours after the fatty meal, it was considered pathologic; and this lack of proper emptying was due to a lesion in the muscular coats.

However, we must be careful to take into consideration the status of the individual, for we have found in the study of these numerous cases that the long, slender type individuals would probably empty much later than the hypersthenic individual.

THE CONTRACTED GALL-BLADDER

It is very essential to study the contracted gall-bladder. In our cases, the contracted gall-bladder has been studied in every instance. This was not done to study evacuation alone, but also to be certain that no small gallstones are being missed. It is erroneous, therefore, to state that no observation is necessary after a fatty meal is given, because it has been found in our series of cases that small calculi have been visible only after the gall-bladder had contracted down to its smallest size. Besides, we have observed that deformities from adhesions are also brought out as the gall-bladder empties. Also, Kirklin [6] found that it was only upon the complete emptying of the gall-bladder that small polpoid tumors could be possibly identified.

DELAYED CONTRACTION

In the study of our cases after the fatty meal, we have found that, unless the gall-bladder contracted down to one-third or a minimum of one-fourth its normal size after four hours, it was reported as "delay in evacuation". We have also observed that in those gall-bladders reported showing good visualization but defective in emptying time were found at operation to be pathologic on this score alone. However, when the gall-bladder did contract down fully to one-third its size after giving the fatty meal, we conclude that the muscular coat could not be seriously impaired.

Furthermore, we have reported a number of cases as "faint visualization" of the gall-bladder. Our roentgen interpretation of the faint visualization of the gall-bladder could pathologically be interpreted as:

1. The gall-bladder was so thickened from old chronic inflammation that the density of the shadow of the dye-laden bile is decreased.

2. That the faint shadow resulted from some interference with the normal function of concentration. This was especially true in acute exacerbations of chronic cholecystitis or in passing oedematous condition of the mucosa of the gall-bladder. In the presence of an acute inflammation there is considerable oedema; and that oedema in the tissue decreases rather than increases absorption.

3. That the gall-bladder is so packed with stones as to allow only a small amount of the opaque dye to enter.

C. PATHOLOGICAL GALL-BLADDER

Therefore, having been careful about our instructions to the patient and after having administered the dye in a single, double or triple manner, as necessity demands, a definite failure of visualization would bespeak of a pathological gall-bladder in fully 98 per cent of cases.

NON-VISUALIZATION

The following pathological conditions in our study gave non-visualization:

a. Chronic cholecystitis.

b. Atrophy of the gall-bladder.

c. Occlusion of the intra-hepatic or extra-hepatic bile duct, neoplastic nodules or inflammatory processes of the ducts themselves.

d. Stenosis of the ducts due to gall-bladder adhesions, scars, etc.

e. Malignant infiltrations.

Of course the surgeon is extremely interested when he receives a report of non-visualization of the gall-bladder. Should he consider every case pathological that is reported by the roentgenologist as a failure of visualization?

From the summation of our cases studied, we might state that non-visualization of the gall-bladder is indicative of pathology if (1) the patient has ingested all of the dye; (2) no acute condition of the gall-bladder or oedema does not or did not exist at the time of the ingestion of the dye; (3) the dye is well disseminated throughout the intestinal and hepatic tracts; (4) and the quality of the films is excellent.

We have also observed that where the icteric index was above twenty, the gall-bladder did not visualize well. Besides, where the qualitative reading of the Van Den Berg was delayed or immediate, we have found stones existing in 88 per cent of cases.

It might be argued that impaired function of the gall-bladder might be attributed not only to diseases of the biliary tract, but also to other organs directly or reflexly affecting the ability of the gall-bladder to receive and concentrate the dye, or to other conditions unrelated to the disease. Our findings, however, directly show us that, where absence of the dye was conclusively proven after giving the double or triple method, a pathological gall-bladder was in most cases found. We must, therefore, again repeat that unless the roentgenographic technic is correct, the shadow of the gall-bladder may be obliterated by movement, or over-penetration, or failure to include the viscus in the region exposed. Overlying gas and fecal material in the intestinal tract may obliterate the shadow. Roentgenologists have always understood cholecystographic data should invariably be weighed in the light of clinical facts. When the respective conditions found are inconsistent, it is the privilege of the clinician to consider whether technical errors may have been made, or whether disease elsewhere may have affected the functional behavior of the gall-bladder. The roentgenologist and the clinician are obliged to coöperate.

In our series where concurrent conditions existed, such as thyrotoxicosis, cardiac insufficiency resulting in chronic passive congestion, intestinal upsets resulting in functional disturbances in either the colon or small intestines, ulcers of the duodenum, hepatitis, cirrhosis and cholangitis, the gall-bladder did not visualize well or at all. We have also found that adhesions could be ruled out definitely if, while the gall-bladder is still filled, we could give the patient a barium meal by mouth in order to fill the antrum and duodenal cap. Under fluoroscopy, we could then obtain the mobility and separability in the upper right quadrant, to rule out any peri-cholecystitis or peri-duodenitis.

Another method for determining adhesions in the gall-bladder is fluoroscopy for direct palpation of the gall-bladder area for tenderness or fixation as well as taking two films, one at the end of inspiration and expiration.

CHOLELITHIASIS

We have observed in the study of these cases that stones in the gall-bladder should never roentgenologically be considered as "innocent". The reason for this conclusion was that all the gall-bladder cases reported as containing stones were found at operation and upon examination to be the seat of a chronic infection. Besides, these stones are in a number of instances responsible for nonvisualization of the gall-bladder due to their becoming lodged in the common or cystic ducts.

It was also noted that in the study of these cases, gallstones were not reported in some cases where the surgeon found them. This is not difficult to understand when we know that gallstones may consist either of calcium, or have cholesterol within them. If stones contain enough calcium to project a shadow on the films, then the Graham test is not indispensable to making a diagnosis. However, where the calcium content is extremely low, they are then invisible except on the x-ray with good technical quality. Where the non-calcified or cholesterol stones are within the gall-bladder,

these are invisible without the entrance of the dye. Therefore, if a stone obstructs the entrance of the dye into the gall-bladder, cholesterol stones will not be observed. This would account for the number of cases wherein we reported no stones, and yet the surgeon found them upon operation.

Non-opaque stones are composed of cholesterol or bile salts, and have insufficient calcium content to be visible roentgenologically unless the dye is given. The opaque bile surrounds the non-opaque stones and shows them by contrast. It also is interesting to note that in these cases where a single stone was found at the fundus, the diagnosis of stone was made rather than tumor because of the shifting around of the positions during emptying of the gall-bladder. Small tumors, on the other hand, do not shift around on the emptying of the gall-bladder shadow. This same finding also was observed by Kirklin.[7] It is well to remember that in the majority of our cases reported in which no shadow was obtained, the diagnosis of possible duct obstruction, as well as pathological gall-bladder, was reported. In our series of cases, there was non-visualization of the gall-bladder in thirty-six cases. Twenty-eight of these occurred as a result of duct obstruction due to stones. Since these stones are *not* always seen, therefore, in reporting, it would always be well to state the possibility of non-opaque stones, otherwise one may be held responsible for not reporting stones found at operation when they existed.

SUMMARY

The purpose of this study was to obtain a more thorough understanding of the physiological roentgen pathology of the gall-bladder checked carefully with all clinical data including surgical as well as pathological reports for a period of five years.

The value of the double as well as the triple administration of the gall-bladder dye is discussed with their relative merits.

Technical errors must also be carefully weighed.

A definite and careful system must be used.

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THE PROGNOSIS IN REGIONAL ILEITIS

By Burrill B. Crohn, M.D., New York City

From the Medical and Surgical Services of Mt. Sinai Hospital, New York City. Abstract of a paper read before the Section on Gastro-Enterology at the Annual Meeting of The Medical Society of New Jersey, June 4, 1936. The complete paper will appear in the American Journal of Digestive Diseases and Nutrition.

In the last four years a considerable literature has appeared centering around the subject of inflammatory lesions of the small intestine, particularly the ileum. Undoubtedly the paper published by Crohn, Ginzburg and Oppenheimer,[1] in which a clinical and pathological description as well as a name was given to the disease, helped to focus attention on the susceptibility of this segment of the intestinal tract to inflammatory lesions.

The predilection of the terminal ileum as a focus of granulomatous inflammation was pointed out, and the significance of both external abdominal wall fistulae and internal visceral fistulae was emphasized. In this earlier paper, based upon fourteen examples of the disease, the low-grade chronic course and benign outlook was predominant; occasional cases with the late feature of small intestine obstruction due to cicatrization were mentioned.

those latter presenting attempts at spontaneous healing.

In a later paper,[2] it was recognized that this very type of benign inflammatory granuloma could involve the jejunum as well as the ileum, a fact which had also been observed by Harris, Bell and Brun.[3] Rarely combined forms of the disease have been noted[4] in which both the ileum and colon have been involved.

Dr. A. A. Berg, who has operated upon a vast number of cases, takes a different view, holding that all such cases are instances of disseminated ulcerative colitis with extension into, the ileum, essentially "right-sided colitis" with incidental overriding of the ileo-cecal valve.

That the disease is widespread and universal would appear from the extensive literature which has appeared in the medical files. Besides the American publications which geographically cover the United States and Canada, Great Britain, Germany, Holland and Belgium have already contributed typical examples.

Aside from the suggestion of Felsen[5] that bacillary dysentery plays a rôle, no suggestion as regards etiology has been advanced.

Just this month Koster[6] has added seventeen cases of his own, confirmed by operation. He has also discussed in an interesting way the clinical features and the prognosis of 127 cases culled from the literature and posed some interesting queries.

In a disease the course of which covers usually many years, four years of experience and observation is obviously too short a period to allow of safe deductions regarding the ultimate prognosis and optimal type of treatment.

Several interesting questions suggest themselves; among these may be mentioned the following:

1. What is the outlook for cases which have undergone radical resection?

2. Is a palliative surgical procedure, such as a short-circuiting operation, warrantable, and what is its ulterior prognosis?

3. What is the proper procedure in the acute type of ileitis?

4. What happens to the case of regional ileitis if no operation is performed?

Dr. A. A. Berg has not only operated and resected the very first cases observed at our hospital, but has recently reported the successful excision of 32 cases; this represents the greatest familiarity and the widest experience known to us at this date. The type of operation advocated by Berg is a wide resection of the diseased process in the ileum, together with the cecum and ascending colon; an anastomosis between the residual ileum and the proximal transverse colon is established. The extent of resection of the ileum is determined (according to Berg) by the degree and latitude of mesenteric lymph adenopathy, since the enlarged succulent lymph nodes in the mesentery are the surest guides to the extent of the inflammatory process in the ileum.

Thirty-two cases with one surgical death probably represents the optimum result as judged by the experience of a mature and capable surgeon.

THE ACUTE TYPE OF ILEITIS

Cases with acute onset, with a history of less than four months, are not infrequent, though beside the rule. In seven instances the symptoms varied from two weeks to four months, often with high temperature, vomiting, diarrhea, occasional collapse. It is interesting to note that in three of these seven cases, obstructive symptoms were already present at the time of operation, indicating that within a few weeks, the entire gamut of inflammation, exhaustion, diarrhea, fistula formation and stenosis may be run. Obviously, the prognosis is altered by the severity and the rapidity of the course of the disease. Two of these patients died; another fatal case followed an attempt at resection, death taking place one week later as a result of exhaustion. Five cases survived resection in the presence of the acute lesion; all have remained well. Palliative attempts at drainage, or of appendectomy or of skillful neglect seem useless.

THE PROGNOSIS OF PALLIATIVE SHORT-CIRCUITING PROCEDURE

Many surgeons have attempted to relieve or cure the disease by anastomosing proximal

healthy ileum to healthy colon, thus short-circuiting the lesion and rerouting the intestinal content over normal mucosa. Studying the records of sixteen such cases leads to conflicting reactions. In nine of these sixteen cases the anastomotic hook-up failed to cure the disease or alleviate symptoms. Eventually, radical resection was forced, in three instances with fatal issue.

On the surface it would appear that palliation is not only futile, but in addition increases the risk of subsequent operation.

On the other hand, I have by courtesy of both Dr. R. Lewisohn and Dr. R. Colp, knowledge of six cases of ileo-colostomy for extensive and severe instances of ileitis.

It is much too soon to try to evaluate the ultimate benefit of such a procedure. That short-circuiting frequency fails, there is no doubt; that it may also at times suffice to cure must remain an open question for the time.

UNOPERATED CASES—THE ULTIMATE PROGNOSIS?

Seventeen cases of ileitis in which no direct operative interference has been practiced are now under observation. The diagnosis has been satisfactorily established and confirmed by clinical means aided by roentgenography, or, as in five cases, by exploratory laparotomy. In these latter instances the lesion was accidentally found in the course of an appendectomy or a cholecystectomy; the lesion was left undisturbed. The first question which is posed is, can ileitis heal itself? Obviously, seventeen cases followed for one to three years cannot afford satisfactory answers to this interesting query.

Three cases went on to a fatal termination as determined by autopsy. All died of peritonitis and exhaustion. Another unoperated case had to be resected after two years because of a rapidly downhill course with fever, diarrhea, mass formation and obstruction.

Four of these cases without operation are seemingly doing well, gaining slightly in weight, showing an occasional slight tendency to diarrhea, but no real abdominal distress and no loss of efficiency. I strongly suspect that these cases will eventually form fistulae, a mass, or become obstructed, though it take years for that eventuality. And yet, scientific precision and clear thinking require one to maintain the premise that a complete restoration ad integrum is within the possibilities of nature.

Another four of these seventeen cases (unoperated) are obviously not improving; the symptoms of mild bouts of diarrhea and cramps continue, associated with fluctuating slight loss or slight gain of weight. Of these cases I feel that the "writing on the wall" is clearly legible. The remaining cases are lost to the present follow-up but will, I hope, because of their value for study, be recaptured.

The problem of treating ileitis by medical palliation can be hardly more than stated; in the fulfillment of time and of study lie the answers. Premature assumption may lead to erroneous conclusions. This eventuality is well illustrated by a recent experience—a patient who had been explored, but not resected, was well for two years, so well that he was considered an instance of spontaneous cure. Accidentally and by chance he was discovered in another institution where he had been operated on in an emergency for small intestinal obstruction, and a segment of diseased terminal ileum resected.

Since obviously two years of complete normalcy of symptoms can simulate good health, then much more time must elapse before final conclusion can be drawn. Perhaps it will be as with ulcerative colitis—who can say when a case is cured, and who insure against a possible recurrence, no matter how long the freedom from symptoms, except where radical resections has been performed.

FATAL CASES

In a disease apparently as benign as regional ileitis it would be interesting to analyze the deaths that occurred in our experience or are known to have happened in cases whose course has been followed. I know of eight such deaths, three of which occurred without the aid of surgery; five deaths followed attempts at surgical procedures, usually with resections. In the three unoperated cases death resulted from diffuse or localized forms of peritonitis, the formation of an extensive suppurative

mass, or as terminal inanition and exhaustion usual with the formation of multiple fistulae. It is fair to say that had these cases been recognized in time, operation would have had a fair chance of success. Careful watchfulness in the face of a spreading and exhausting process availed not at all.

CONCLUSIONS

Final conclusions should not be drawn from the incomplete facts presented in this paper. The series of cases is too small; and the time elapsed is too short to allow for decisions to be made.

In the best of hands the prognosis is excellent when a radical resection is performed. The mortality rate is low, the end result excellent.

Palliative short-circuiting procedures, as well as skillful neglect and so-called conservative medical treatment, are still on trial, and the prognosis still to be determined.

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THE TREATMENT OF GOITER AND ITS COMPLICATIONS

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Read before the Hunterdon County Medical Society, October 27, 1936, in Flemington.

In this paper there has been an effort made to expound the views of the group of which the author is a member on the care of patients suffering with goiter with particular reference to the use of iodine and to present some statistics from our own cases regarding the important medical complications. This has been prefaced with some remarks on the classification and diagnosis of goiter. Malignant and inflammatory disease of the thyroid gland have not been discussed.

CLASSIFICATION

The terminology suggested by the American Association for the Study of Goiter has been used in our work for some time. It is as follows, with synonymous terms given in parenthesis.

1. Non-toxic goiter
   a. Diffuse (Endemic goiter, adolescent goiter)
   b. Nodular (Adenomatous goiter, colloid goiter)
2. Toxic goiter
   a. Diffuse (Graves' disease, Basedow's disease, primary hyperthyroidism)
   b. Nodular (Toxic adenoma, secondary hyperthyroidism)
3. Malignant goiter
4. Inflammatory disease

The classification is useful and simple. A ready correlation between the clinical and pathological findings is possible.

DIAGNOSIS

Diffuse non-toxic goiter occurs with great frequency in goiter districts such as Switzerland and the Great Lakes region of the United States and sporadically elsewhere. A symmetrical soft enlargement of the thyroid gland appears most frequently at puberty, during pregnancy, or other periods of stress. The disorder is most common in females. No signs of hyperthyroidism are present, and the basal metabolic rate is often below normal. The only diagnostic difficulty is presented by patients with mild nervous symptoms attributed mistakenly to the goiter; in these cases a differentiation from toxic goiter must be made.

The identification of the non-toxic nodular goiter is usually readily made with the examination of the irregularly enlarged gland, which usually develops during the first half of adult life. One or many nodules may be present, producing at times an enormous tumor. The breaking down of an encapsulated nodule often

produces a cyst. Through the size of the tumors, symptoms result from pressure on the recurrent laryngeal nerves, the trachea and the esophagus. Further it must be remembered that intra-thoracic extension is frequent.

The goiter may lie entirely within the thorax, and no thyroid tissue may be palpable. In this connection Lahey and Swinton [1] recommend that any patient with signs of mechanical obstruction of respiration should be suspected of having an intrathoracic goiter. The greatest number are associated with dilatation of the veins of the head and neck. By x-ray examination, displacement and narrowing of the trachea by the tumor may be demonstrated.

The differentiation of toxic goiter into diffuse and nodular types is purely an academic matter, for hyperthyroidism is the same disease with both forms of enlargement.[2] Toxic diffuse goiter occurs chiefly between the ages of twenty and forty, although it may occur at any time; toxic non-diffuse goiter occurs most always after the age of thirty.

The diagnosis of hyperthyroidism depends on the history of enlargement of the neck, nervousness, emotional instability, loss of weight in spite of increased appetite, sweating, an intolerance to heat; diarrhea may also be present. On examination, one finds the enlargement of the thyroid, which may be only slight in diffuse goiter; purposeless movements, hyperhidrosis, tremor, increased tendon reflexes, tachycardia, and the eye signs. The classical ophthalmological findings are staring, exophthalmos, widening of the palpebral fissure, lid-lag, and infrequent winking; oedema of the eyelids may be present. The systolic blood pressure is elevated without a corresponding rise in the diastolic pressure. It should not be necessary to mention that all the symptoms and signs are frequently not present in each patient, and that striking exceptions such as obesity may occur.

The most important laboratory examination is the determination of the basal metabolic rate, which may be increased to 80 or 100 per cent above normal. Here a word of caution must be given that the estimation must have been made by a competent observer and further that the rate may not be elevated or may have been reduced to normal by treatment. Blood iodine studies may offer an important addition to the means of differentiation in the future. Perkin, Lahey, and Cattell [3] have recently discussed this subject and offer an iodine tolerance test as a further aid.

TREATMENT

The therapeutic problem of non-toxic, non-diffuse goiter depends on the accepted etiological factor of the lack of iodine. In his early work Marine administered two grams of iodine to preadolescent school children in a period of two weeks twice each year. At the present time Marine [4] advises the general use of iodized salt in concentrations of 1/100,000 or 1/200,000 for the prevention of this type of thyroid disease. As shall be seen later, the use of higher concentrations of iodized salt is not advised. In Detroit McClure [5] found that the percentage of goiter in school children dropped from 35 per cent in 1924 to 1.44 per cent in 1932 after iodine had been routinely given the children beginning in the former year. Marine [4] lists as the further late results of this prophylactic administration of iodine the decrease in non-toxic diffuse goiter at the time of pregnancy, in non-toxic nodular goiter, in toxic goiter, in cretenism and congenital goiter, and finally in malignant thyroid disease.

The developed non-toxic diffuse goiter is the only form of goiter that should be medically treated with iodine. The dosage should always be small and be combined with careful medical care. Clute and Pilcher [6] advise the administration of iodine in amounts of one grain a week only. Goetsch [7] uses iodine in doses no larger than ten or fifteen milligrams a day, the larger amount in young adults; in addition he gives thyroid extract in doses of one-quarter to one-half a grain daily while watching the patients closely for signs of hyperthyroidism. His results are good among young adolescents; thyroidectomy must occasionally be performed in later years for the size of the diffusely enlarged gland or because use of the development of nodular goiter.

The treatment of non-toxic non-diffuse goiter is strictly surgical. Along with the unsight-

liness of the enlargement and the pressure symptoms there are present the dangers of the development of hyperthyroidism and malignancy, which occurs chiefly in nodular goiter of long standing. We have recently operated upon a patient with a nodular goiter of five years' duration with gross invasion of a large vein by a portion of the tumor shown to be an embryonal adenoma. The pre- and postoperative care of this type of goiter does not present any special problems.

There is no place here for the use of iodine, because iodine hyperthyroidism, the Jodbasedow of Kocher and Breuer, may be induced. Jackson and Freeman,[8] who have observed a a number of patients suffering with iodine hyperthyroidism, do not believe that any adenoma will become toxic before the age of thirty unless iodine has been taken. In the study of McClure,[5] an increasing number of patients coming to operation for goiter, largely with toxic adenomas, was noted in 1927, three years after the generalized use of iodine for school children and iodized salt had been begun. Investigation in the seven largest hospitals in Detroit, Grand Rapids, and Ann Arbor showed an increase in the number of thyroidectomies in 1926 and 1927 with a gradual decline since those years. In 1933 60 per cent less thyroidectomies were performed than in the high year 1927 with a decline of only 17 per cent in the total number of operations. The increase had only been in nodular toxic goiter. The death rate from goiter in Michigan showed a similar rise in 1925, 1926 and 1927 with a decline thereafter. McClure concluded that a number of nodular or adenomatous goiters had been activated with iodized salt, the peak of toxicity production being attained two years after the use of the salt had been begun.

Marine[4] agrees that iodine will activate nodular non-toxic goiter. In the use of iodized salt he warns that it must be kept away from individuals with developed nodular goiter, and that especially must the higher concentrations of iodine, 1/10,000 and 1/5,000, be avoided. Unfortunately a great many of the preparations on the market are of the higher concentrations, a danger that is only too easily not understood by the patient and the public.

The results of surgery in returning those afflicted with hyperthyroidism to useful life are not to be questioned. Undoubtedly certain cases of hyperthyroidism will respond to medical care under favorable conditions, although invariably only after prolonged rest and invalidism. Means[9] questions that medical care is ever advisable at the present time. Even in mild cases there is often present an economic question better solved by operation with its more rapid and assured recovery. It is generally granted[10] that a five per cent rate of recurrence after operation may be expected. Means,[2] who has had a large experience, states that roentgenological therapy is definitely inferior to surgery. We have recently had under our care a patient who had had an excellent result with combined medical and x-ray treatment. Several others, however, have been operated upon following unsuccessful treatment with x-ray.

PRE- AND POSTOPERATIVE CARE

The patients suffering with hyperthyroidism must be carefully treated in the hospital before operation. It is our custom to administer phenobarbital as is necessary to the patient confined to bed. Iodine in the form of Lugol's solution is given in doses of five minims three times daily for three or four days and then the amount is doubled; occasionally larger quantities are given to refractory patients. The diet consists of protein limited to one gram for each kilo of body weight, fat of about forty grams, and carbohydrate of eight or nine hundred grams to supply over four thousand calories a day; by increasing the carbohydrate any further demands of hunger may be met.

With this regime the mental and physical condition of the patient improves, and the basal metabolic rate and the pulse rate fall. Operation is deferred until the maximum benefit has been attained, usually between the seventh and tenth days. The best single indication of the suitability of the patient for operation is the pulse rate, which should fall below one hundred and remain so for several days. This beneficial change, largely dependent on the iodine administration, lasts only for about three weeks and operation must take place during this period. Further, no operation should be

performed on any patient who has not been suitably and carefully prepared.

ANAESTHESIA

During the earlier years the anaesthetic generally used was nitrous oxide and oxygen with the occasional employment of local anesthesia. For the last sixty-seven cases of all sorts of goiter avertin in the rather full dose of ninety or one hundred milligrams per kilo body weight has been used supplemented with nitrous oxide. There has been a recent exception made because of a severe diarrhea, which accompanied the other symptoms of hyperthyroidism. The only ill effect attributable to the avertin was an incident with rapid shallow respirations persisting for some hours after operation. Its greatest advantage is the post-operative quiet and sleep that persist for from three to six hours at a time during which the patients would otherwise be in their greatest discomfort.

The avertin is best administered to the patients in their own rooms. With those more than usually apprehensive patients an effort is made to give the anaesthetic without their knowledge. For several days before the planned operation the patients are given a small dose of morphin hypodermically at seven A. M. and one hour later a saline rectal irrigation. On the morning of operation one-quarter grain of morphin and one one-hundred and fiftieth grain of scopolamine hydrobromide are given and at eight the avertin. The patient should have been earlier told that the date of operation would not again be mentioned. This procedure may be satisfactorily carried out in a two- or three-bed room.

THE OPERATION

There is no place in this discussion for the details of the operative procedure. Customarily portions of both lobes of the thyroid were removed. In four patients the operation was divided into stages: in two first one lobe and then the other was resected; in the third, bilateral ligations of the superior thyroid arteries preceded the resection of the gland; and in fourth a unilateral ligation was performed first. There is one patient in whom one lobe was resected and who has not returned for the second operation although his symptoms have persisted. Two patients have been operated upon for recurrent hyperthyroidism; one of these has had three secondary operations and is now moderately well with the aid of x-ray therapy; the other is quite well following a second operation. These two patients are the only examples of recurrent hyperthyroidism that we have seen. In all, one hundred and ninety-three operations have been performed on the one hundred and ninety-eight patients considered in this study.

POST OPERATIVE CARE

During the post-operative period care must be taken to abundantly supply fluids and carbohydrates to the patient, who is generally more comfortable in a sitting posture. Two thousand c.c. of normal saline are given by hypodermoclysis immediately after operation. Following the awakening from anaesthesia, water and liquids sweetened with lactose are given; glucose is generally administered intravenously during the first twelve hours and again later should vomiting and nausea interfere with intake by mouth; this is generally not necessary, for surprisingly large amounts are usually taken if they are properly presented. Lugol's solution is prescribed three times a day in five minim doses. The patients are usually out of bed in five or six days and may return home in a few more.

Proper nursing care and surroundings are essential for the best results with hyperthyroidism. Through the coöperation of the Sisters of St. Francis, these patients, private and ward, are placed in adjacent portions of the hospital under the same supervisors, who have become interested and experienced in their care. The rooms are cheerful and quiet and contain no more than three beds. Because of inability to pay for it, no apprehensive patient is ever denied a single room. Since the institution of this policy we have had decreasing difficulty with the care of the goiter sufferers.

THE PLACE OF IODINE

Since the administration of iodine is the most important factor in the preparation of the patient with hyperthyroidism for operation,

its proper use must be understood. Of equal importance is the knowledge of the occasions on which it should not be used. The usefulness of iodine in the prevention and treatment of non-toxic diffuse goiter and its danger when given patients with non-toxic non-diffuse goiter have been described.

The beneficial effect of iodine on the acute symptoms of hyperthyroidism, due, it is thought, to the mechanical effect of the increased colloid content of the acini, is only of three weeks' duration; it is during this time that operation must take place. The remission so induced is followed by exacerbations more distressing than beforehand. It is the general opinion that the secondary remissions attainable after an abstinence from iodine are less marked than the primary. Clute and Pilcher [6] state that in their experience iodine given before admission to the hospital only increased their difficulties. Goetsch [11] reports that 40 per cent of his fatalities following thyroidectomy were due to crisis; of the seventeen patients dying of this cause fifteen had been given iodine indiscriminately before admission to the hospital; he strongly advises against the medical use of iodine in hyperthyroidism, for it does not cure and deprives the surgeon of his most reliable factor of safety, namely the preoperative clinical remission otherwise obtainable by the first and efficient intensive treatment with iodine.

The danger of iodine given these patients, unless before intended operation, cannot be too strongly stressed. The seriously affected patient may die of incontrollable thyroid crisis while in a refractory period following the taking of iodine. Great care must be taken to elicit a history of iodine medication when examining a sufferer with hyperthyroidism.

An illustration of the incorrect use of iodine is afforded by the following history:

A white woman, Mrs. J., No. 35-3952, was seen in the office on September 13, 1935, with a history of swelling in the neck of nine years' duration. For several months she had noted increasing nervousness and sweating accompanied by a loss of twenty pounds weight. Since taking iodine for three weeks, she had felt considerably better. On examination the thyroid gland was bilaterally enlarged and nodular; nervousness, tremor, sweating, and exophthalmos were present. BP 190/90, pulse 124.

It was thought best to postpone preparation, and admission was deferred until October 6; the BMR was then plus 37 per cent. The usual preoperative care was given. On October 12 a planned operation was postponed because of a rise in the pulse rate to 120 before the anaesthetic was given. On October 15 the pulse rate rose to 160 after the administration of the avertin, and operation was again deferred and the patient discharged.

She was readmitted on March 7, 1936, after office care, and again prepared. On March 14 both lobes were resected successfully. During the operation the pulse rate ranged from 94 to 120. Convalescence was uneventful, and the patient is in excellent condition at the present time.

We see here the patient made iodine fast through unwise administration. The operative preparation attempted during the refractive period was unsuccessful. After waiting some months an excellent result was obtained, but it is unfortunate that the patient should have had second hospitalization and additional invalidism.

In our experience the secondary iodine remissions are quite as satisfactory as the primary ones, provided that the necessary two or three months has elapsed after administration.

We have noted no difference in the response of patients with diffuse and with nodular goiters to iodine. This is in accord with the findings of Frazier and Johnson.[10] Mayo and Mayo [12] and Crile [13] state that the response of patients with adenomatous toxic goiter is less marked than of those with diffusely enlarged glands. In the experience of Jackson and Freeman,[8] certain cases of toxic adenoma were resistant to iodine preparation. In their study

Diagnosis	Number			Age			Average Pulse *	Basal Metabolic Rate			
	Total	M	Fe	Av.	High	Low		No.	Av.	High	Low
Non-toxic Diffuse	6		6	20	22	16	86	3	—8	—1	—14
Non-toxic Nodular	60	4	56	33	67	17	86	30	5.3	24	—19
Toxic Diffuse	85	11	74	34	59	12	117	70	46	83	12
Toxic Nodular	37	4	33	44	62	26	107	28	43	77	14
Thyro Cardiac **	29	1	28	43	62	17	136	25	46	82	14

* Apical rate when auricular fibrillation present.
** 17 Diffuse, 12 Nodular.

62 per cent were benefited and 38 per cent made definitely worse. Potter and Morris [14] found that 11 per cent of patients with exophthalmic goiter and 3.6 per cent with toxic nodular goiter were resistant to iodine; 38 per cent and 40 per cent of these patients respectively gave a history of previous iodine medication, while iodized salt had probably been taken by all those studied.

A summary of the findings in the one hundred and eighty-eight patients with goiter operated upon at the St. Francis Hospital by Dr. G. N. J. Sommer and Dr. D. L. Haggerty in the years 1926 to 1936 is given in the accompanying table; there are no cases of malignancy of the thyroid included. The patients are listed according to diagnosis with a relisting of the thyrocardiac patients in order that a ready comparison may be made with the three groups of non-toxic nodular, toxic diffuse, and toxic nodular goiter.

In the table may be noted the total number of cases in each group; the number male and female with the preponderance of the female; the average and extreme ages; the average pulse rates computed from the first two records after admission; and the average and extreme basal metabolic rates. The figures for the basal metabolic rates were not available for all patients.

The largest number of patients had toxic diffuse goiter. This finding is the usual one in the Eastern United States. Frazier and Johnson [10] in 965 cases had 60 per cent with diffuse and 20 per cent with nodular toxic goiter. Higher figures for non-toxic nodular goiter are found from other parts of the country.

It is interesting to note the increasing number of patients coming to operation in recent years. From 1926 until 1932 inclusive ninty-three patients were operated upon with two fatalities, and from 1933 until 1936 inclusive ninty-five with one fatality. This rise in number has been in all groups and is apparently due to a growing incidence of goiter as well as to a greater confidence in the immediate and late results of operation.

DIABETES

The two most important medical complications of hyperthyroidism are diabetes mellitus and cardiac disease. Attention to the association with diabetes was first called in this country by Fitz [15] in 1921, who found nine cases of diabetes among 1800 of hyperthyroidism, an incidence of 0.5 per cent. Wilder [16] in 1926 stated that the association was merely incidental, for he had found only 1.1 per cent diabetics among 3471 patients with hyperthyroidism, two per cent in adenomatous goiter and 0.6 per cent in exophthalmic goiter. In 1928, however, Joslin and Lahey [17] again emphasized the relation of the two diseases and found that 2.45 per cent of their patients with primary hyperthyroidism and 4.27 per cent with secondary hyperthyroidism had diabetes. They further discussed the generally altered carbohydrate metabolism and the glycosuria so often found without real diabetes. In 1934 [18] they added fifty-six cases to their earlier seventy-five, and stated that their mortality had been reduced to 1.6 per cent due to an increased number of multiple stage operations to 22 per cent. John [19] found 207 diabetics among 9000 patients with thyroid disease and recommends that a blood sugar determination be made in all patients with suspected hyperthyroidism.

In our group of 124 patients with hyperthyroidism there were two diabetics with diffuse and three with nodular toxic goiter, a total incidence of four per cent. All these patients met the criteria of Joslin and Lahey [17] of having a fasting blood sugar of 150 in addition to glycosuria. There were three other incidences of glycosuria without diabetes; one of these patients had a fasting blood sugar of 125, but was definitely shown not to have diabetes.

The treatment of diabetes associated with hyperthyroidism is on the same general principles as with other surgical conditions. Diabetes properly controlled with insulin is not a contraindication to operation. Delay in controlling hyperthyroidism permits increasing severity of the diabetes, which is usually very favorably influenced by the return to normal thyroid activity. There is no evidence shown

of diabetes by one of our patients four years after operation. Three patients were greatly improved in tolerance to carbohydrate; neglect of diet in two of these women led to a recurrence of elevation of the blood sugar. The fifth patient was apparently improved, but unfortunately died of pneumonia four months after her operation.

There was no instance of diabetes or glycosuria noted among the sixty-six patients with non-toxic goiter.

CARDIAC DISEASE

The development of cardiac damage under the influence of hyperthyroidism is a common occurrence. The criteria necessary for the diagnosis of hyperthyroid cardiac disease are hyperthyroidism and one or all of the following: cardiac enlargement, permanent or paroxysmal aricular fibrillation, and signs of cardiac failure. A systolic murmur is often heard at the base or the apex of the heart, but its presence is not necessary for diagnosis and it may be present without cardiac disease.

It should be mentioned here that at times the chief evidence of hyperthyroidism may be an auricular fibrillation that has failed to respond to the usual remedies. We have seen several patients whose cardiac failure has persisted for several years in spite of digitalis, diuretics, and rest. With the administration of iodine followed by surgery they have been completely relieved. No complete alleviation of the cardiac symptoms may be expected without control of the etiological factor.

There are twenty-nine patients listed as having cardiac disease secondary to hyperthyroidism; a summary has been given in the table. Fifteen of the patients had auricular fibrillation and twenty-two had signs of cardiac failure. The majority of patients with failure respond to iodine, bed rest, and the restriction of fluids before operation. The use of salyrgyn has been very helpful with several patients. Digitalis seems to be only necessary when the cardiac rate with auricular fibrillation is above 120; it is not necessary with slower rates. Operation should not be attempted with more than the slightest evidences of decompensation present. The preoperative period of care is slightly longer as a rule than with the uncomplicated cases.

In all these patients auricular fibrillation ceased before the discharge of the patient from the hospital. With several, quinidine sulphate has been used after operation in doses of three grains each four hours until normal sinus rhythm has been restored; this has occurred always within seventy-two hours. In no patient has it been necessary to continue medication directed toward the heart for more than a few weeks after discharge from the hospital.

An interesting example is afforded by a white man, aged twenty-seven, No. 33-296, who was admitted with severe hyperthyroidism and auricular fibrillation with an apical rate of 204. Fibrillation ceased after a right lobectomy. The patient was discharged from the hospital to return in six weeks for resection of the left lobe, but failed to do so for eighteen months. At the second admission no signs of cardiac disease were present in spite of the persistance of hyperthyroidism, which was completely relieved by the resection of the left lobe.

It is in this group that two of the three fatalities occurred. The first two were in 1926 and 1927, due to thyroid crisis.

In 1934 the third patient died of cerebral embolism following restoration of normal sinus rhythm from auricular fibrillation after operation. It should not be thought that an expected mortality could be calculated from this small number of cases.

In closing the discussion of the cardiac complications of hyperthyroidism, it should be mentioned that the assistance of a well-trained cardiologist is of the greatest help in the care of these patients. In this we have been very fortunate to have had the one consultant for the entire period, who has given freely of his time and interest.

CONCLUSION

The need of adequate preparation of patients suffering with hyperthyroidism for operation cannot be too strongly emphasized. Most important for this is the administration of iodine,

a drug of the greatest value, which has been too often incorrectly used in the treatment of goiter. It should be given only in the careful prophylaxis and treatment of diffuse non-toxic goiter and in the preparation of the patient with toxic goiter for operation. There is no place for the use of iodine with non-toxic nodular goiter.

The control of the two important medical complications of hyperthyroidism depends on the treatment of the disease of the thyroid gland.

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INTRAPARTUM CARE IN RELATION TO MATERNAL WELFARE

MATERNAL WELFARE ARTICLE NUMBER FIFTEEN

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Intrapartum care is the greatest single problem of the physician in dealing with the pregnant woman, since guidance and management of the woman in labor is solely in his hands. The Yale Committee stressed this point in their tentative opinion, "Perhaps the most important benefit which prenatal care can bring to the expectant mother is the conviction that she must arrange for good obstetrical attendance at the time of her confinement." Their investigation led them to the belief that improvement in the quality of care during labor offers much greater possibilities for lessening the hazards of child-bearing than does further elaboration on prenatal care, the relative importance of which may have been over-emphasized lately.

Good intrapartum care necessitates an understanding of the normal mechanism of labor; an ability to recognize abnormal conditions which may arise during labor; and a knowledge of the accepted methods of treatment for the mechanical hazards and physiological abnormalities which may occur, as well as of the basic principles of asepsis. Good intrapartum care, therefore, is dependent almost entirely upon the ability of the attendant, who must be well trained in the science and art of obstetrics.

UTILIZING PRENATAL EXAMINATIONS

To be specific, let us review briefly the knowledge a physician should have of his patient when she falls into labor. He should be familiar with her general physical and mental make-up including the presence of any medical complications such as cardiac lesions, anemia, or pulmonary disease. He has inquired about her previous labors, if there were any,

and has learned if there was an operative interference in former deliveries, as well as the indications for and the results of such operations. From his study of the pelvis he knows if disproportions is present or not, its degree and if the case is a border-line one requiring careful test of labor. This knowledge is gained from pelvic measurements with, at times, assistance from the roentgenologist. This latter service shows advancing benefit to both mother and baby. Through inspection, palpation, and auscultation during prenatal examinations he has learned the position and the presentation of the child, or possibly the presence of a multiple pregnancy. By means of abdominal and rectal examinations during the late weeks of pregnancy, he has determined the relation of the presenting part to the pelvis. Prenatal treatments, when indicated, have been given to aid in eliminating foci of infection from the lower birth canal and have either cured or controlled venereal diseases such as gonorrhea. Accurate knowledge as to the size of the pelvis, of the position and presentation of the fetus, and the relation of the presenting part to the pelvis, helps the doctor to minimize the number of examinations during labor.

OBSTETRICAL HAZARDS

All this detailed information about the patient makes the physician more competent to give her adequate assistance at the time of labor. He should keep in mind always the four major obstetrical hazards,—toxemia, dystocia, hemorrhage and sepsis. He has practically eliminated toxemia through excellent prenatal care, but he should remember the effect of parturition upon the potentially toxic or mildly toxic patient. He has considered the possibility of dystocia by his obstetrical examinations, and has made preparations accordingly. He will know whether it is advisable to proceed promptly with Cesarean section, or to plan a careful, watchful delay in cases of occiput posterior or of breech presentation. He will obviate hemorrhage as far as possible by avoiding trauma and lacerations during delivery, and by desisting from vaginal operative deliveries with an atonic uterus. For any emergency hemorrhage, he will be adequately prepared. He will guard against sepsis by strict adherence to the principles of aseptic surgery.

During the time, 1931-1934, of our survey of maternal deaths in Philadelphia, there were seventy-nine deaths from accidents of labor. This group included not only rupture and inversion of the uterus, but all deaths occurring during Cesarean section, version, forceps, and breech extractions, as well as cases of shock classed either as operative or postpartum, and many other accidents, all of which were really attributable to dystocia. Various surveys both here and abroad have shown that careful inquiry into the history of the cases dying from accidents of labor often show that the doctor is at fault on one count or another. At times the avoidable factor is some error in technic, but more frequently it is an error in judgment either in deciding whether to interefere or not, or in selecting the time to intervene, or the method to be employed.

CALLING CONSULTANTS

The increasing popularity of hospitalization of obstetric patients has led to an enormous rise in the number of operative deliveries by attending physicians who are not properly qualified. Some communities have attempted to restrain this growing tendency. In regard to this situation, the American College of Surgeons and the Committee on Maternal Welfare of the Medical Society of the State of New Jersey have made recommendations which have been adopted rather widely, often with suitable local modifications. They suggest that all hospitals accepting obstetrical cases adopt the rule of calling a qualified consultant under the following circumstances: All prolonged labors (twenty-four hours for courtesy men) and ward cases twelve hours; cases requiring Cesarean section; breech presentations (unless very premature); difficult forceps cases or versions; occiput posterior presentations requiring forceps or version; and other complicated cases, such as eclampsia, abruptio placenta, or placenta previa.

In the Philadelphia survey, almost none of the cases dying from accidents of labor had had consultations prior to operation. It is a well-known fact that the average so-called open

or privately conducted hospital seldom imposes any restrictions on the amount or type of obstetric surgery which may be performed by the attending physicians. In some carefully conducted hospitals the courtesy staff of the maternity department is restricted as to the type of work permitted. Obstetricians known to be qualified are allowed full operative privileges. General practitioners are limited to spontaneous deliveries, perineal forceps, or manual assistance in breech deliveries. Under all other circumstances they are required to have consultations.

Obligatory consultations in cases of long labor, twenty-four hours or more, would tend toward earlier recognition of disproportion, thus eliminating needless delay which so often results in the delivery of choice becoming an extreme hazard from shock or potential sepsis. In cases of long labor due to inertia uteris, breech, or posterior occiput, a consultation may permit further delay with safety, or it may provide a more decisive conclusion. When Cesarean section is contemplated, counsel is highly commendable. It will either justify the obstetrician in proceeding with the operation, or it may spare the woman unnecessary intervention.

There is no doubt that consultation in breech presentation is of great value to both mother and baby. It has been estimated that the average fetal mortality of all breech presentation is 20 per cent, and the morbidity for the fetus that survives is equally high. Consultations often lead to conservative treatment preventing untimely breech decomposition and extraction which frequently results in dangers to the mother such as rupture of the uterus and severe lacerations.

If consultation were required in difficult forceps cases and in versions, many lives would be spared. Certainly numerous difficult high forceps deliveries with consequent stillbirths incapacitating injuries to the birth canal might be handled better by low cervical Cesarean section. Cases of long labors, with an absence of amniotic fluid and the formation of retraction rings, would fare better if delivery were accomplished by forceps, or even by craniotomy if the fetus were dead, rather than by resorting to version.

In intrapartum hemorrhage cases, consultation would have a twofold benefit. First, the patient would have the advantage of two opinions as to the best method of handling the case. Second, the attendant would have the help of his adviser in the actual delivery and in the carrying out of supportive measures.

CESAREAN SECTIONS

Classical Cesarean section is still the operation of choice for cases of previously recognized disproportion. The low cervical section, however, has many advantages in cases of long labor with potential infection. This fact is not recognized sufficiently, yet every survey on maternal mortality presents convincing evidence that this type of operation should be adopted more widely under such circumstances. The infrequency with which the Porro operation is performed in cases of undoubted or evident infection is deplorable. This operation, or craniotomy with a dead child or one whose life is questionable, should be considered more often in cases of infection.

FORCEPS

In reporting on operative deliveries to the White House Conference, Plass makes the statement that forceps are needed in obstetric practice in not more than five per cent of the cases. Contrast this figure with the forceps incidence in some hospitals ranging as high as 60 per cent of all deliveries. In the hospitals of Philadelphia, our survey showed the forceps incidence to be about 20 per cent of all cases delivered. It is evident that prophylactic or elective low forceps with some type of epsiotomy have come to stay, whether justified or not. The follow-up study of Aldridge in the New York Women's Hospital seem to indicate better end-results from the use of prophylactic forceps than from spontaneous delivery, in so far as the integrity of the pelvic floor and the absence of cystocele and rectocele are concerned.

Forceps used in the mid-pelvis or above this plane should be considered a major obstetrical

procedure for which definite indications should be present. Whether or not consultation is demanded by hospital rule, it might behoove the younger practitioner to seek wise counsel and skillful assistance in early work of this type. Bumm's axiom should always be kept in mind: "It is the duty of him who uses the forceps to convince himself that the conditions for the safe use of the instrument are fulfilled."

VERSION

Performance of version necessarily carries a definite hazard for both mother and child. The contra-indications for its use must always be absent. In the Philadelphia survey, it was noted that flagrant disregard of the presence of one or more of the contra-indications to version seemed to be the responsible factor in the majority of fatal cases. Most of the versions were performed on cases of prolonged labor with the amniotic fluid completely drained away. One-half of the deaths from rupture of the uterus followed version. One-third of the version deaths were associated with shock or rupture of the uterus. These facts emphasize the disastrous results following untimely choice of this procedure.

In breech presentation with full dilatation of the cervix, the routine extraction of the fetus is still a debatable question. One Boston group preaches this radical interference for the benefit of the child. Other clinics advocate and practice conservatism, and interfere only when certain indications exist such as extended legs, slow progress, and mild disproportion between the body and the pelvis. In our Philadelphia series, over five per cent of the total maternal deaths occurred in connection with breech extractions, the majority of which were regarded as untimely or poorly performed. Because of the inherent dangers to both mother and fetus in breech presentations, it is essential that the operator have good judgment and considerable skill in the management of these cases when interference is deemed necessary. There is no doubt that conservative treatment of breech presentation gives the best results to both mother and fetus except in unusual circumstances and in expert hands.

HEMORRHAGE

Hemorrhage from placenta previa, or premature separation of the placenta, is dealt with more easily by abdominal delivery. This treatment diminished blood loss, and assures comparative safety for the child. Under certain conditions, however, symptomatic treatment must be resorted to such as rupture of the membranes, forceps, version, introduction of bags, or packing of the birth canal where it can not be avoided. The greater frequency of sepsis occurring in cases of hemorrhage delivered by the vaginal route is a strong argument in favor of abdominal delivery.

Postpartum hemorrhage often denotes improper handling of the third stage of labor. Frequently, for no apparent reason, the placenta is forced out of the uterus too soon after delivery. This betokens a lack of understanding of the physiology of uterine contraction and retraction and the mechanism. For prophylaxis, the newer ergot preparation administered subcutaneously or by rectum are of value in women subjected to prolonged ether anesthesia. For unavoidable postpartum hemorrhage resulting from uterine deficiency or inefficiency, preparations should always be at hand for packing the uterus and for restoring body fluids by transfusion or saline infusion.

SEPSIS

The work of Mayes in Brooklyn is convincing evidence that the intravaginal instillation of mercurochrome, or similar antiseptics is of value. It may not be necessary to adopt this practice routinely, but it gives an added sense of safety in case of rupture of the membranes during a test of labor with a possibility of Cesarean section or when forceps, version, or breech extraction are thought to be inevitable.

The avoidance of sepsis depends largely upon the avoidance of trauma. The first step is to minimize the number of examinations made, especially through the vagina. Under normal conditions, rectal examinations should supersede vaginal examinations for many reasons. They are made quickly with little preparation. They readily determine the progress of labor as to descent and dilatation; and, even

if repeated, they do not tend to increase the incidence of infection. With the patient in the lateral position, contact of the hand with the perineo-vulvar area or vaginal outlet is avoided. When vaginal examinations are deemed advisable, both the patient and the physician should be prepared as if for actual delivery.

There are many ways by which the physician can guard against the entrance of septic organisms through avenues of trauma. He should treat every case conservatively; but when intervention becomes necessary, he should select the proper time to operate, and should choose the method of delivery that will cause the least trauma. He should refrain from manual dilatations of the partially dilated cervix. He should allow the head to descend to the pelvic floor under continued analgesia rather than resort to high pelvic operations. He should wait for spontaneous separation and expulsion of the placenta instead of extracting it manually.

FOOD

General care of the parturient woman necessitates careful attention to diet. During labor she should receive sufficient amounts of easily assimulable, highly concentrated foods. In certain situations, such as prolonged labor with the imminence of inhalation anesthesia, it may be necessary to give intravenous injections of glucose. When the stomach is not retentive, it is advisable to supply the required fluids intravenously or subcutaneously. Elimination should be watched, and the rectum and bladder should be emptied at regular intervals either spontaneously or by enema and catheter.

PAIN

Besides these general considerations of food and fluid intake, and of elimination, we must regard relief of pain as a necessary factor today. Suitable methods of treatment produce analgesia or amnesia as well as safeguard the patient's physical resources, by allaying her mental anxiety and conserving her natural defenses. No routine method can be recommended for this purpose. The kind and dosage of the drug employed must be chosen according to the needs of the individual patient. This is true also of anesthesia when operative intervention is necessary. The decision depends upon the personal judgment of the attending physician.

PRENATAL CARE

Intrapartum care forms but one portion of our program for supervision of the pregnant woman. Prenatal care prepares both the expectant mother and the attending physician for the advent of child birth. Postnatal care implies continued supervision of the patient until a return to normal is reached or approximated. During the intrapartum period, the physician is responsible for carefully watching the normal process of labor; for being on the lookout for any developing hazard or complications; for maintaining a cautious attitude toward intervention; and for having courage to proceed with obstetrical surgery promptly and efficiently should true indications arise.

THE ANNUAL MEETING

TO PRESIDENT SNEDECOR

As High Priest in the Temple hall
Annointed at your brethren's call,
You graced the line of chosen men
Who through full eight-score years and ten
Have ministered each holy rite,
And by its glowing altar light
Have read the trends of present days
And prophesied of future ways.
May flames from off that altar fire
With burning zeal the soul inspire
Of him who now assumes your part
Within the temple of our art.

THE YEAR IN RETROSPECT

PRESIDENT'S ADDRESS AT THE ANNUAL BANQUET

By Spencer T. Snedecor, M.D., Hackensack, N. J.

Delivered at the President's Banquet at the Annual Meeting of The Medical Society of New Jersey, on April 28, 1937.

Physicians throughout the nation are awakening to the full implications of a new era, not only in the conquest of disease, but also in broadening the scope of health services to our people, the growth of hospitals and institutional care, the development of accessory services by nursing organizations and lay health groups, and the widespread approach to public health problems.

HEALTH CONSCIOUSNESS

Our nation is developing its social consciousness, and is seeking to provide the opportunity for better health and good medical care to the rank and file of the multitude. This movement is the logical result of two factors: First, the education of the masses to desire better things; and second, the recognition of scientific accomplishments in public health and medical science. We may also believe that the people understand what constitutes a high quality of medical service, and that they have a desire to receive it.

With the passage of the social security legislation we became acutely aware of this social change. Now we find that mighty waves of public health fervor are sweeping over the country. We, the doctors, have been only too conscious of some of the shortcomings of our calling in relieving the vast misery of human suffering and illness, and also in taking advantage of our patent opportunities for the preventive of sickness.

Withal, we have been proud that American Medicine has set high standards which are above those of any other country on earth. But at the present moment we are almost overwhelmed by a public interest and demand for more health measures. It is therefore necessary that we recognize the significance of this movement in order that we may keep an even balance and a forward path for the health wheel of which we are the hub.

The millions of dollars provided for the Social Security Program by the Federal government started a movement which quicly gained widespread impetus and public support. Vast sums are now avaliable to help crippled children, and the blind; more to lower the death rate of childbirth; and added millions to afford each child good health.

Nor is this confined to the Federal program. One of our great cities has voted one million dollars for a five-year campaign against tuberculosis. Our neighboring state recently received a request for one million dollars for pneumonia serum for the poor, and immediately granted $400,000 for this new and promising remedy which has hardly had the test of experience.

Health is in the air. Leading magazines find the public psychologically ready for health ap-

peals; and the editors are playing it up strongly. One magazine chooses cancer, another tuberculosis, a third maternal mortality, —and the public response is financially profitable to them.

HEALTH BY LEGISLATION

With the legislature and the public the gesture of an appropriation of a large sum of money for a worthy purpose concludes their effort. It seems so simple. Let us appropriate enough money, they say, so that every crippled child will have the best of care. But that only opens the door to the mechanism of distributing the services which these children need. Our experience with rehabilitation programs has taught us that, unless we are most careful, the overhead of dispensing such funds may climb to fifty per cent of the appropriation. A new bureau, a corps of investigators and clerks, a search into the potential needs of each case,—and presto, half the funds do not reach their objective at all. And frequently the doctors who will actually produce and deliver the services are the last workers to be remembered.

THE CHALLENGE TO PHYSICIANS

Whether or not this Social Security health protection and sickness care will evolve itself into a lasting and successful system, is yet to be determined; but we physicians must take part in the effort. To us this is a tremendous challenge.

In retrospect we see that for years we have been nibbling at public health programs of which now we must all of a sudden take great gulps. Some parts of the public health activities are coming so rapidly that they are giving us indigestion. Great new tasks are being dumped into our laps from day to day, each one needing medical guidance and leadership.

In the approach to a higher standard of model service there are many correlating and accessory agencies working with the physicians; but tonight we are concerned directly with the doctors. We must look to the doctors as the leaders of all organized and personal medical endeavor, because through years of training and experience they are the ones who best know the technic for distributing medical services to the people.

And in truth, we find that the practice of medicine now consists of two parts. First and foremost, the physician must render a constantly improving quality of his own personal care to his patients. Secondly, he must join organized groups in order to supply needy patients with preventive services in addition to his curative care. The day of the isolationist physician has passed, and now the doctors can round out their full complement of duty only by uniting together in organized medical effort.

The privileged position as President of The Medical Society of New Jersey has enabled, yes compelled, me to study all phases of the problems with which the State-wide medical organization is faced; and as I resume my status of a private in the ranks of the profession, I can say, consciously and thoughtfully that the medical profession is meeting today's health needs as rapidly as the individual doctors can organize themselves, and make preparations to deliver their services.

MATERNAL WELFARE SERVICE

Let us take, for example, what the physicians of New Jersey have done for maternal welfare. With the objective of lowering maternal and child mortality during childbirth, the doctors of Essex County met a decade ago and formed the first Maternal Welfare Commission to be established in the United States; and later spread their activities to the other counties. As the funds of the Social Security Act became available last Summer, special activities were undertaken by our State Maternal Welfare Committee, and by a similar group in each county. Under our program of coöperation with the State Department of Health, field physicians for promoting maternal activities were appointed in sixteen districts of the State.

The Maternal Welfare Committees have studied the maternity service in every hospital and maternity home in New Jersey. They have recommended standards for delivery-room technic, for the better supervision of internes, for the better care of babies, and for keeping proper records. Through these committees post-graduate courses in obstetrics and pre-

natal care have been provided for hundreds of doctors. Frequent consultations have been advised when any complication of pregnancy appears.

More adequate and more frequent prenatal examinations, including Wassermann tests for syphilis, have been recommended. Every maternal death in this State is investigated and reported by a field physician to see if it cannot be avoided in the next similar case. Nurses are being paid for care of mothers during their delivery in the homes of poor patients. Doctors are being paid for consultations in such cases. Unfortunately, since the Emergency Relief Administration passed, no real attempt has been made to pay the doctors for obstetrical service to the poor. Here is a glaring defect which must be recognized and met. We estimate that about .... of the patient are delivered free by the doctors.

On the basis of a five-year accomplishment, we have lowered the maternal death rate in New Jersey by 37 per cent in five years. Over 100 fewer women died in childbirth in New Jersey last year than in 1931,—a hundred lives saved each year. We challenge any state or any foreign country to show a better record. We say that the mothers in New Jersey are getting as good medical care as anywhere else in the world.

HEALTH INSURANCE

There is a tendency on the part of socially-minded individuals to hope for immediate perfection in the delivery of medical services, and so they plan some form of health insurance. They feel that tax money, with government regulation and control through an insurance scheme, will assure the people of better service; but they have not set themselves down to discuss the problem with us, the physicians, who are the deliverers of these services. They hope for service of a high quality from every doctor, and they are forgetful that there are grades of physicians even in this most carefully selected and most highly educated profession in the world. They seek to have every medical need satisfied without thought of the cost, and whether or not the public wants it. There is no simple, easy path to a more perfected health service. The problems are great. Essentially they will be answered through the education of our profession, and also by the public.

What place should the government have in this picture? We recognize the necessity for government funds for many health services, and hospital contributions. Frankly, the cost of modern medical care is so prohibitive that a great mass of individuals cannot meet it. It is true also that modern public health is expensive, but not because the doctors profit. The gross income of a physician today probably averages more than ever before, but the expenses of good office equipment, accessory services, and post-graduate education, and free service given to a large part of his patients have kept his net income down to an exceedingly low and modest average.

It is time that due attention be paid to the medical care of the poor by municipal and State agencies, and by the social groups. Tax funds for this purpose are essential. Due public consideration must be given to this need, and the physicians in turn will organize to care for these people. Let each individual patient choose his physician; and let the doctor be compensated a reasonable amount. The adjustment of fees and the supervision of the service can be arranged with each county medical society, or the State Society as a whole.

SPONTANEOUS HEALTH ORGANIZATION OF PHYSICIANS

Our hope is that the government will not go rashly into radical changes of the methods of distributing medical services in the vain hope of gaining objectives quickly; but that it will continue to permit us to organize and control these improved services. So far we have found Washington to be sincerely cooperative in allowing us to have a large share of responsibility in supervising these health plans. If this attitude continues, we have little to fear, for we are confident that the best medical services will be rendered if the trained medical profession keeps control of their distribution.

We must recognize that there are many pitfalls along the road to health and social se-

curity. Let us proceed slowly enough to give the time-tested and proven methods opportunity to work.

My experience as President of The Medical Society of New Jersey has convinced me that we in the profession have shown that we can organize ourselves for the better distribution of our services. I have found the physicians of New Jersey ably meeting this challenge of our modern era. They are responding splendidly and adequately to the health needs of our times. Our attention is directed to the program of the public health activities and contacts of our Society and its individual doctors. The Handbook of Preventive Procedures for the physicians of New Jersey which we have pust published will stand as a guide and objective for better public health practice for many years to come. And since we are alive to our responsibilities, we can look confidently to the future of medical practice.

Medicine is the most unselfish of all professions. Without respect to race, or creed, or nationality, its high ethical standards are the same the world over. Its scientific language is universal; its practitioners belong to a common guild devoted to the service of humanity. The members of The Medical Society of New Jersey are exemplifying these high ideals.

OBJECTIVES OF THE MEDICAL SOCIETY OF NEW JERSEY

PRESIDENT'S INAUGURAL ADDRESS TO THE HOUSE OF DELEGATES

By William G. Herrman, M.D., Asbury Park, N. J.

Delivered at the 171st Annual Meeting of The Medical Society of New Jersey at Atlantic City, on April 28, 1937.

Fellow-members of The Medical Society of New Jersey, I appreciate deeply your greeting, and will comment briefly on some of the more important phases of the work of our Society.

PRESIDENT'S CABINET

Dr. Snedecor, during the past year, started a happy innovation which I intend to continue. He has considered the President-Elect, the two Vice-Presidents, the Chairman of the Board of Trustees, and the Chairman of the Welfare Committee as his Cabinet. He has called upon them for aid and assistance in carrying on the work of his office. I am going to call upon them very shortly after this Annual Meeting to formulate with me a program for the coming year based upon the desires of this Society as indicated by the action which the House of Delegates takes at this meeting.

SCOPE OF ACTIVITIES

At this time, let me merely say I feel the past administration has been a most successful one, especially in improving the organization of the Society, in amplifying the work of the county societies, and in integrating their work with that of the parent society.

Much time and thought has been given in coöperating with government agencies, in the medical aspects of the Social Security Act, to wit: maternal health, child health, venereal disease, crippled children and old-age pensioners.

HOSPITAL SURVEY

For years we have talked about correlation of the medical and the administrative side of hospital activities. In the past year for the first time has any attempt been made to survey the hospitals of the State through a questionnaire. We hope to continue this investigation and have ready for you next June some recommendations.

WORKMEN'S COMPENSATION

The proposals of the Workmen's Compensation Act Committee, I believe, merit our support. An effort will be made during the coming year to have conferences with the Department of Labor, employers, and Insurance

carriers, so as to modify some of the more objectionable features of the present Workmen's Compensation Act.

CANCER CONTROL

The survey of the Cancer Control Committee has shown how sadly lacking are the present facilities in this State for coördinative care of the cancer case, be it indigent or private. Pneumonia or typhoid fever can be taken care of by one physician, but many cases of cancer, to be adequately treated, must be handled by a group. It is up to us to develop a plan by which such group treatment can be made available in the various sections of our State. This program will be one of those which I hope to emphasize during the coming year.

PREVENTIVE MEDICINE PRACTICE

Our Public Health Committee has attempted, during the last few years, to recapture for the private physician many phases of preventive medicine which we ourselves have allowed to stray into the hands of the laity, to our loss and, I believe, with less benefit to the public than if they were carried on by medical men themselves.

GENERAL PUBLICITY

"Big Business" has demonstrated for years that any article could be sold to the public, provided it was sufficiently advertised. The ban against advertising by the individual physician, incorporated in our code of ethics, has been interpreted by a great many physicians as prohibiting advertising by medical organizations. But in this day and generation, if we wish to influence the public mind to see things as we see them, we must advertise our wares. We have been fortunate, in the past year, in forming a Public Relations Committee which gives great promise of extending proper medical information to all parts of the State. We hope to extend and amplify the work of this committee.

NURSING EDUCATION

The Committee on Nursing Education has devoted considerable time and thought to preparing a two-fold plan for providing better nursing facilities for both hospitals and those who are ill at home and do not or cannot afford the help of a registered nurse. We believe that this active committee can be continued and encouraged.

The State Medical Society as at present organized, representing more than a majority of the practicing physicians in this State, may logically expect to speak officially for all of the physicians of the State in its contact with other organized groups of citizens or with State or governmental agencies. But this fact should not deter us from making every effort to amplify the number of our members, so that we may include every ethical physician in New Jersey.

In due time a detailed program of the coming year will be published in the Journal. Until then, may I state that by and large, we feel that the policies of the past recent administrations should be continued—that we approve, by and large, the work of the various committees during the past year, and hope that this work will be continued along much the same lines.

MONMOUTH COUNTY IN THE MEDICAL SOCIETY OF NEW JERSEY

By WILLIAM G. HERRMAN, M.D., Asbury Park, N. J.

The Address of the Incoming President at the Banquet of the Annual Meeting of The Medical Society of New Jersey, April 28, 1937.

The large delegation of Monmouth County doctors and their wives that you see in this banquet hall has come to make this a Monmouth County night, the rest of the speakers and the program belong to you, but I belong to them. You can hardly blame them, after being in the background so long, for making the most of this occasion. It is sixty-three years since the Monmouth County Medical Society furnished a president to the State Society.

Thomas James Thomason was President of this Society from 1873 to 1874. From that time to this, Presidents have come and gone each year, but none from Monmouth County. I am sure you will then bear with me, if I pay some tribute to Monmouth County, its Society, and its members.

"Breathes there a man, with soul so dead,
Who never to himself hath said,
This is my own, my native land!"

In this day of internationalism, of the clash between classes and masses, perhaps the love of family, pride of locality, and patriotism are passé, but I do not think so. I believe the true love of humanity is noblest born in the breasts of those who take pride in both those and the place from which they come. We have an old and glorious medical society in this State, founded in 1766; and Dr. Bishop, that is why the word "State" is not in our name. There was no "State" of New Jersey at that time, this was well before the birth of our national independence and in the early history of this Society, and of this nation Monmouth County citizens and doctors played a leading part—believe it or not.

May I remind you of Dr. James Newell, who lived in Freehold and was President of the State Medical Society in 1772? He served as surgeon in the Continental Army. His son Elisha practiced in Shrewsbury, and was President of the State Medical Society in 1795. This was twenty years before the founding of the Monmouth County Medical Society.

In 1816, following the disorganization caused by the War of 1812, the Medical Society of the State of New Jersey met at New Brunswick, and under a new charter granted by the State of New Jersey organized five district societies. As a result of this, the four following physicians met at the Monmouth Court House on the 24th of July, 1816, and formed a District Medical Society: Edward Taylor, William G. Reynolds, Samuel Forman, and Jacobus Hubbard. Now if you will go to the rooms of the Woman's Auxiliary on the thirteenth floor, and look at the historical exhibits you may see the ledger of Dr. Jacobus Hubbard, extending from 1791 to 1800 with the charges rendered in pounds, shillings and pence; and on the next page "per cantra" the entries show that he was paid in horse fodder, and in board and lodging for oftentimes for himself as he packed his saddlebags in Eatontown and set out for a two-week trip down toward Manasquan where it is alledged but never proved that they hitched lanterns to cows tails and waved them up and down the beach so that ships might possible come ashore. We find these and other Revolutionary names still very prevalent in Monmouth County. In fact, at the present time, of the four men named, there are still doctors by the name of Taylor and Reynolds practicing in our county. Following the formation of our Monmouth County Medical Society, there were five physicians who became Presidents of the State Society—one about every twenty years, until 1874. From then on, there has been no one so honored from our district.

Monmouth County has been blessed with many fine specimens of that genus homo, the family doctor, the guide of youth and the comfort of old age, and in order to be up-to-date, we must say, quite modestly that we have our show also of that much imitated individual,—the specialist. Time is too short to mention

many outstanding characters. Three of them should be mentioned, since they became nationally known. Dr. William A. Newhall became Governor of the State, member of Congress, and White House physician to President Lincoln. Later, he was Governor of the Territory of Washington, and he established the life saving service on our coast. Then there was a doctor from Monmouth County who became Governor George Franklin Fort; and Dr. Peter Knieskern, who was an outstanding authority in his day in botany and made a survey of the flora and fauna of New Jersey.

Finally, our county has produced another son and sent him down to Trenton; and I hope that when the year is passed, the doctors of the county which has not had such an heir for many years, will feel that the Lord has smiled upon them and not laughed out loud.

We come from a section of the State which is rich in history. Back and forth over the fertile plow lands fought the armies of the Revolution, and one of the outstanding battles of this great struggle was, as you know, the Battle of Monmouth. We are considered to be the third richest agricultural county in the United States. Within our borders are many nationally-known summer resorts. A visit to our pleasant land will well repay any of you, be you interested in a vaction, in historical records or in finding a country estate.

I am reminded of one of our local residents, who, taking a trip to the West to attend a meeting of the Shriners, stopped off on the trip to view the Grand Canyon of the Colorado. While the rest of the party waxed enthusiastic over the glories of Nature spread before them, he remained apparently unimpressed. The party's guide finally became picqued at Andy's lack of enthusiasm, and turning to him, he said, "Sir, are you not impressed by the magnitude of this handiwork of Nature spread before you?" Andy replied, "Yes, I am, but I only wish I had you back home to show you the potato fields of Monmouth County."

Such loyalty for one's locality is inherent in the residents of Monmouth County, but I think that such loyalty is more or less natural to the citizens of the State of New Jersey. I am reminded of the trip which Governor Moore, now Senator, made to California, where he was asked to speak before a large audience, and was introduced as the Governor of New Jersey, "one of our smaller Eastern States". Upon rising to recognize the introduction, Governor Moore said, "Yes, New Jersey *is* one of the smaller of the Eastern States, but I notice that the pottery upon which we have dined this evening comes from Trenton. I note that the draperies in this banquet hall were made in Paterson, and the drop curtain on the stage behind me came from Newark. This serves but to show that things of value are often put up in small packages."

Last Fall, while attending a post-graduate course in Chicago, I happened to be seated at dinner next to a doctor from Arkansas. When he found that I was from New Jersey, he said, "You have a very active and splendid medical society in the State of New Jersey. I am the Secretary of the Arkansas Medical Society, and I wait eagerly each month to read in the Journal of your society what you have been doing recently."

Ladies and gentlemen, we *have* an active, well-organized State Society. We are trying to be of service to the public at large, to government agencies, and to the individual doctor as he goes about his daily tasks. We are in a period of unrest and change. No one knows what tomorrow will bring forth. Customs of yesterday are "gone with the wind". But we, as physicians, have a service to render. We are indispensable. Civilization, as we know it, could not exist without the active, daily function of medical and allied sciences.

With the active support of the members of this organization, your officers feel that they will be able to find, little by little, the solution of our professional problems, not alone for our own benefit, but for the good of all mankind, and we expect to find it in an American way. To that end, I pledge my earnest efforts during the coming year, and ask your loyal support.

THE ANNUAL MEETING

The 171st Annual Meeting of The Medical Society of New Jersey, held in Haddon Hall, Atlantic City, on April 27-29, 1937, was among the most successful that have ever been held. Many members went so far as to say that it was *the best,* and no one was heard to deny the assertion.

The attendance exceeded that of last year, which had held the record. (Journal, June 1936, p. 363.) This year's statistics are as follows:

THE MEDICAL SOCIETY OF NEW JERSEY
171ST ANNUAL MEETING

REGISTRATION

County	Delegates	Members	Woman's Auxiliary	N. J. Visitors
Atlantic	8	87	51	131
Bergen	14	11	10	15
Burlington	5	17	13	1
Camden	11	35	21	9
Cape May	4	12		1
Cumberland	4	16		6
Essex	52	63	29	32
Gloucester	5	13	9	14
Hudson	27	30	11	17
Hunterdon	2	2		3
Mercer	12	33	15	12
Middlesex	5	25	10	8
Monmouth	9	46	16	16
Morris	6	13		9
Ocean	2	10	6	4
Passaic	13	18	10	7
Salem	1	6		3
Somerset	3	14	7	4
Sussex	1	1		
Union	19	33	14	11
Warren	2	6	4	2
Total	205	491	226	305

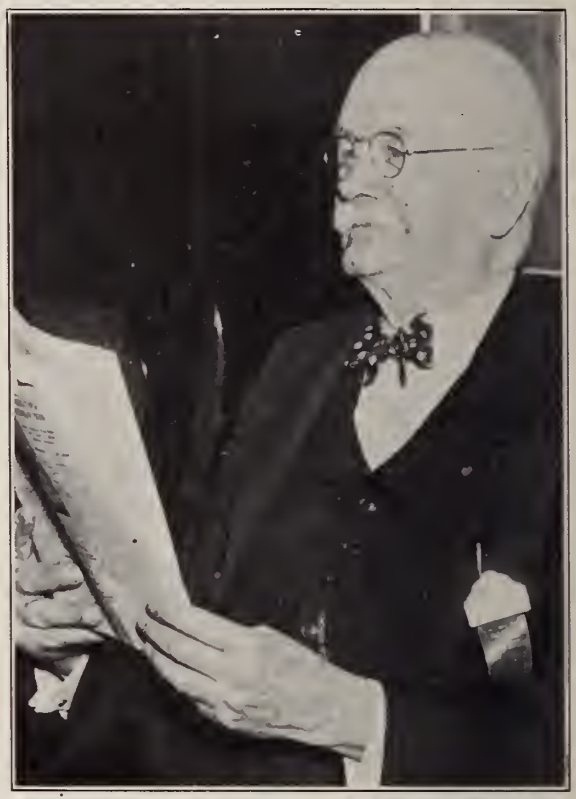
SUMMARY

Delegates	205	
Members	491	
Visitors—N. J. Physicians	27	
Visitors—Out-of-State Physicians	40	
		763
Woman's Auxiliary		226
Visitors—New Jersey		305
Visitors—Out-of-State		16
Exhibitors		77
Total Registration		1387

DR. HARRISON'S ATTENDANCE RECORD

A pleasing feature of the enrollment was the presence of Dr. Joseph B. Harrison, of Westfield, Union County, who was attending the Annual Meeting of The Medical Society for the sixty-first consecutive time,—a record which probably never will be duplicated.

Dr. Harrison was born in 1852. He graduated in medicine from the University of Alabama in 1876, and from the College of Physicians and Surgeons, New York, in 1877, and at once began practice in Westfield, where he has remained ever since. His name appears in the Transactions of The Medical Society of New Jersey for 1877 as a member of the Union County Medical Society; and on every Official List since that year.



DR. JOSEPH B. HARRISON

Dr. Harrison attended every available session this year and recalled the days when the programs consisted almost entirely of scientific papers interminably long and profoundly philosophical.

ARRANGEMENTS

A great factor in the success of the Annual Meeting was the grouping of all its features on the floor immediately above the main office, and adjacent to the dining rooms of the hotel. As a member approached the meeting-place, he first entered the aisles of the technical exhibits, and approached the registration desk, and the information desk where some representative of the Society was always present.

Next came rooms occupied by the scientific exhibits, on one side of which was the large assembly hall for the House of Delegates,

while smaller rooms within easy access were available for the scientific sections and the reference committees.

The Woman's Auxiliary had its headquarters on the thirteenth floor, in the rooms which in previous years had been used by the State Society.

PLANNING THE MEETING

The programs and arrangements for the events were made more carefully and promptly than ever before, as was shown by three facts:

1. The program was ready for the printer at an earlier date than ever before; and few last minute changes were necessary, in contrast with the experience of the past few years.
2. The county societies were more coöperative in formulating the plans than ever before.
3. The program was the logical culmination of the year's work in integrating the activities of the State Society with those of the county societies.

WELFARE COMMITTEE

A great factor in the integration of the varied activities of the State Society was the example set by the Welfare Committee throughout the year. The Welfare Committee has fulfilled its mission of bringing together the score of committees engaged in those activities which are concerned with the private practice of medicine. Its meetings have been forums in which the members of all the participating committees have met at frequent intervals and heard the proposals of each unit, and decided all plans of action in their relation to the balanced program of the entire group. The detailed reports of the constituent committees had been set forth in The Journal at intervals throughout the year, with the result that there was a high degree of agreement regarding the efficiency of the several committees which were concerned with the *external* relations of physicians, or those relating to their duties to the public.

HOUSE OF DELEGATES

The internal or *business* affairs of the Society elicited sharp differences of opinion regarding a few points. These disagreements were expressed in the opening session of the House of Delegates and were referred to the appropriate committees of the House of Delegates. These committees held protracted night sessions and heard the complaints and suggestions from proponents of all sides of the questions. Disputed points were argued by those who were directly concerned, and informations were given freely. Every inquiry and every protest was heard, the final judgments of the Reference Committees were accepted by the House of Delegates in almost every instance, with few dissenting votes.

DUES

The principal point in dispute in the House of Delegates was that concerning the dues for the coming year. Throughout the past months, The Medical Society of New Jersey and its component county societies have given serious consideration to methods of meeting the criticisms of the great Foundations that a large proportion of the people were financially unable to secure efficient medical services except for conditions which were so fully developed that successful treatment was impossible without an undue burden on hospitals and relief agencies. The essence of the criticism was that the services of preventive medicine were not being made available to a large proportion of low-wage earners, as well as to indigents. During the past few years this subject had been widely discussed under the name of "State Medicine", whose essence was that governments—Federal, State, and municipal—should provide *all* medical services at public expense. The Welfare Committee and its component committees had reached agreements with governmental agencies regarding the fields of activities of the two groups. The governmental and the medical agencies—in which the voluntary health agencies were also included.

The establishment of the central offices of The Medical Society of New Jersey, with an experienced staff, has been essential in carrying out a unified plan of action in agreements with accessory agencies. Here the records of all committees are kept, correspondence has been carried on, and assistance rendered to all the groups, especially the county medical societies. This year, for the first time, information—both reliable and complete—has been made available to all the members, and coördination and integration of effort have been made possible.

The two departments of the executive offices—the administrative and the editorial—have worked together in harmony, and summaries of all society activities have been made available by organized means among which the following may be enumerated:

1. The visitation of county societies by the Executive Officer and the President's Cabinet.
2. The monthly Journal.
3. Periodic letters from the President mailed to all the members of county societies.
4. The preparation and distribution of the

mimeographed minutes of the meetings to all committees of the State Society.

The cost of these essential activities has been met from an annual assessment of thirteen dollars per member, which the Committee on Budget and Finance reported should be increased to fifteen dollars—an increase of two dollars, or sixteen per cent.

The expenses of the central executive offices have been met by an integration of the former scattered administrative units into one central office; but the several State committees and the county societies are making increased requests for service which the committee on Finance and Budget can provide only by an increase in dues.

Several county societies had passed resolutions approving the increase; but one of the larger societies had made a formal protest against the increase, and had requested explanations of the details of the past expenditures and the proposed extension of the services. The Reference Committees devoted hours to hearing the protests and the explanations of the officers, and their proposals for the increase in dues were adopted by the House of Delegates by a unanimous vote.

HONORARY MEMBERSHIP

There was a formal request for an interpretation of the Constitution and By-Laws regarding the standing of those members on whom honorary memberships had been conferred. The House of Delegates recognized a possible contradiction in the phraseology of the Constitution and By-Laws, and voted to refer the question to the Standing Committee on Constitution and By-Laws, with the request that it submit the proper amendments which would enable honorary members to retain all the prerogatives of active membership; and the House also passed a resolution that those members who now were on the honorary list should be considered eligible to hold office and to retain all other rights and prerogatives pending the adoption of the proper amendments insuring those rights and prerogatives beyond question.

Another important decision was that concerning the official status of the Secretary. The establishment of the executive offices had produced the practical results that the records were transferred from the private offices of the Secretary to the executive offices; but the House of Delegates voted unanimously that in view of the great amount of disinterested service which Dr. J. B. Morrison had given during his fifteen years as Secretary, he should be made Secretary Emeritus; and be given an annual honorarium of fifteen hundred dollars.

REFERENCE COMMITTEES

Following the custom established at the Annual Meeting of 1934, by President Quigley, the House of Delegates conducted the major part of its business through Reference Committees. These committees were appointed in March, and to them were referred all the annual reports of the officers and committees. These Reference Committees had a month in which to study the sixty pages of reports which were published in the April Journal. They held hearings at which protests and suggestions were heard, thereby avoiding long debates on the floor of the House, and insuring a serious consideration of the questions raised and suggestions made by any member. The reports of the Reference Committees constituted the order of business of the last session of the House of Delegates, and in every instance the House adopted their suggestions of approval or for provision for their further study by the proper Board or committee.

ELECTION OF OFFICERS

The Nominating Committee, which is provided by the Constitution and By-Laws, gave serious consideration to the choice of candidates for the elective offices. Since the Nominating Committee consists of the Junior Past President, and one member from each county society, elected by vote of the Society, the system of nominations is well-nigh perfect and representative.

The nominees named by the Nominating Committee were unanimously approved by the House of Delegates.

Dr. William G. Herrman was automatically advanced to the Presidency, he having been elected to that office at the Annual Meeting in 1936.

Dr. William J. Carrington was advanced to the office of President-Elect; and Dr. E. Zeh Hawkes to that of First Vice-President.

Dr. Watson B. Morris, of Springfield, Union County, was chosen Second Vice-President, and Dr. Alfred Stahl, of Newark, was elected Secretary.

For Treasurer, Dr. Elias J. Marsh, of Paterson, was continued in office for his sixteenth consecutive term. Dr. Marsh has inherited his name and his spirit of service from his father, who was elected President in 1891, and also from his grandfather, who was chosen President in 1850.

SCIENTIFIC EXHIBITS

The scientific exhibits filled a large hall adjoining the registration table, and every one of the fifty-two booths was taken. The presence of demonstrators to explain the exhibits helped to attract the doctors and to hold their interest. The aisles were filled during almost all the hours that the exhibits were open.

The exhibits covered a great variety of subjects, which were listed in the April Journal, page 242, and in the printed program, page 14. They included a great variety of medical subjects,—x-ray, pathological specimens, both fresh and preserved; charts of physiological methods, and processes of treatment. Social measures were also included, and charts of methods of coöperation of lay agencies with medical organizations. With demonstrators to explain the specimens and charts, the exhibits were ideal methods of importing knowledge of the newer methods of diagnosis and treatment.

The exhibits were planned and managed by a committee of which Dr. Asher Yaguda, of Newark, was chairman. The committee planned to award certificates to the exhibitors, and placques to the most meritorious.

Photographs of the most striking booths were made and will be published as a series in the Journal as features of equal value with the papers which are read before the scientific sessions.

THE SCIENTIFIC PROGRAM

The scientific programs of the sections were prepared in three divisions:

1. Public Health in its modern conception.
2. General medicine.
3. The specialties.

The Public Health Session.—The Public Health Session on Tuesday evening was addressed by three outstanding leaders.

Dr. Charles Gordon Heyd, President of the American Medical Association, spoke on the doctors' adaptation to the changing times, and the need that they should take an active part in all public health programs in order that the leadership may remain under medical direction and control. The impression which he left was that The Medical Society of New Jersey is developing satisfactory methods of meeting new social conditions.

Dr. Thomas Parran, Surgeon General of the United States Public Health Service and lately Health Commissioner of the State of New York, spoke on Venereal Disease Control from the standpoint of both the practicing physician and governmental participation in the local programs. The Public Health Service will supply the publicity which will arouse the people to accept the ministrations which the people need.

Dr. Howard W. Haggard, Professor of Physiology in the Sheffield Scientific School of Yale University and the author of popular works such as "Devils, Drugs, and Doctors", outlined the principles underlying the participation of practicing physicians in public health programs. He showed that the practice of medicine consisted largely in the adoption of social methods so that the doctor will secure the active coöperation of both the individual patient and the public.

Each paper was intensely practical, and will be published in an early issue of the Journal.

GENERAL SCIENTIFIC SESSIONS

Two sessions on general medicine were held, and were addressed by thirteen experts. These addresses were eminently practical and will be published in the Journal.

THE SPECIAL SECTIONS

Four sections on the specialties were addressed by twenty-five physicians, some local and some guest speakers from outside the State. These papers too will be published in the Journal during the year.

THE PRESIDENT'S BANQUET

The Banquet and Ball on Wednesday evening in honor of President Snedecor was the formal social feature of the Annual Meeting. This was arranged under the auspices of the Woman's Auxiliary, and was followed with a ball during which some of the newer dances were demonstrated.

Over four hundred doctors and their wives attended the banquet, so that the diners overflowed the banquet hall into the adjoining rooms; but all assembled in the main room for the after-dinner speaking and entertainment.

A feature of the banquet was the presence of a large delegation of President Snedecor's fellow members of the Bergen County Medical Society, and an even larger delegation of fellow members from Monmouth County in honor of President Herrman.

The after-dinner speaking was opened with greetings from Mrs. George A. Rogers, President of the Woman's Auxiliary to The Medical Society of New Jersey.

President Snedecor gave the Presidential Address, in which he reviewed the events of his administration. (See page 335.)

Dr. William G. Herrman, the incoming President, told the medical story of his home county of Monmouth, and the past its physi-

cians had taken in the activities of the State Society. (See page 340.)

Dr. Frederick J. Bishop, President-Elect of the Medical Society of the State of Pennsylvania, brought medical greetings from New Jersey's nearest neighbors and the State in whose medical school a large proportion of New Jersey's doctors were educated.

The addresses were broadcasted over Station WPG. The Kiwanis Glee Club of Atlantic City, of about fifty voices, rendered a series of songs in honor of the doctors and their wives.

PUBLICITY

The publicity plans which had been made by Dr. Joseph H. Kler, Chairman of the Committee on Public Relations, were carried out most efficiently.

1. Dr. Kler had secured the addresses of three-fourths of the speakers on the program; and had made summaries and distributed them to all the leading newspapers of the State.
2. He maintained press headquarters in the registration room, where he and the editor met the reporters and gave them news of what was happening; and whenever possible, advance sheets of the addresses.
3. He assisted the press photographers to obtain photographs of the officers, many of whom were unduly camera-shy.
4. Dr. Kler broadcasted accounts of the meetings every afternoon over Station WPG.

A full report of the publicity work of the Public Relations Committee will be printed in the "Transactions".

THE WOMAN'S AUXILIARY

The convention of the Woman's Auxiliary to the Medical Society of New Jersey was the most successful in its history. The Auxiliary occupied the rooms on the thirteenth floor which in former years were assigned to the Medical Society, so that the Auxiliary had an abundance of room.

The program of the Auxiliary was carried out pleasingly and efficiently, and will be reported in the "Transactions".

EXHIBITS

The main assembly room of the Auxiliary contained the largest array of exhibits that the members had ever assembled. These were grouped in three divisions of Arts, Hobbies, and Medical History; but as a matter of fact, the three merged together, for history is an art, and requires the compelling spirit of a hobby.

An address on the opportunities of the Auxiliary was given by Dr. Frank Overton, emphasis being given to the suggestion that a Committee on Historical Mementos and Records be appointed, with a branch committee in each county. The special activities of the committee would be as follows:

1. Find out what records and mementos are in existence, and examine them.
2. List each article, making a special note of its nature, and the place where it may be seen.
3. Prepare photographs of the relics, or photostats of the documents or copies of the writings for preservation and publication.
4. File the information with the Executive Offices, whose facilities for conducting correspondence will be at the disposal of the committee.

New Jersey is rich in known medical history; but rich mines of information still await the investigations of the explorer.

EXPENSE

The question is sometimes asked, "How can the treasury of The Medical Society of New Jersey meet the expense of all the varied features of the Annual Meeting?"

The answer is that the Annual Meeting yields a profit to the Society, the income being derived from two sources:

1. The rent of booths to the technical exhibitors.
2. The extra amount of advertising which is offered to the Journal for the number immediately preceding the Annual Meeting,—that of April being by far the largest in the history of the Journal. Evidence of the growth of The Medical Society of New Jersey and its component county societies in influence and popular respect is the fact that its facilities are sought by high-class commercial firms in a constantly increasing degree.

STATE SOCIETY ACTIVITIES

MEMORIAL TO DR. JOHN F. HAGERTY

The following memorial to Dr. John F. Hagerty has been beautifully engrossed in a booklet sent to his family:

The members
of
THE MEDICAL SOCIETY OF
NEW JERSEY
as friends and colleagues of
DR. JOHN F. HAGERTY
express their love and affection for him
in this tribute to his memory.

Endowed with strength of body, mind, and soul
You freely gave from your abounding store;
And like the Great Physician of us all
You grew in favor with both God and Man.
Your life a benediction, prayer, and praise,
You showed your brethren how we too may serve.
Triumphant you re-live your life with God,
Our hearts aglow from your own heavenly light.

Adopted by the Board of Trustees of The Medical Society of New Jersey, March 7, 1937.

Andrew F. McBride, Chairman of Memorial Committee
Frederic J. Quigley, Chairman of Board of Trustees
Spencer T. Snedecor, President of The Medical Society of New Jersey



DR. JOHN F. HAGERTY,
in the year 1916, when he was President of the Medical Society of the County of Essex.

Reproduced from The Journal of August 1916, page 419. A recent photograph of Dr. Hagerty was printed on page 186 of the Journal of March 1937.

PUBLIC HEALTH COMMITTEE

A meeting of the Public Health Committee was held at 3:00 p. m., in the Academy of Medicine, Newark, April 7th, 1937. Chairman Dr. Stanley Nichols presided, and those present were: Drs. Nichols, Teimer, Orton, Overton, Kahrs, Ireland, Kler, Jaffin and Pollak.

TUBERCULOSIS

The tuberculosis bills were discussed. Dr. Pollak stated that he feared it was too late to do anything about them this year, but he would like to have them approved by the Society, and if possible ready for introduction next year if they could not be put through this year.

VENEREAL DISEASE

Dr. Nichols, in discussing the venereal disease program, stated that there were three ways in which funds were distributed in connection with this program:

1. A direct grant from the Federal Government to a large city (Newark, New Jersey) as an unconditional contribution toward their regular venereal disease work. This program is in no way a part of or subject to the supervision of the State Health Department. In the case of Newark, it would be advisable for the Essex County Medical Society to discuss the Newark situation with its own Health Department.

2. The State venereal disease funds consist of the State's appropriation and the Federal matching funds for which the State is responsible. These funds, under the control of the State Health Department, are used for matching similar amounts provided by county governments; and are then subject to the provisions of the agreement made between the State Department of Health, the Bureau of Venereal Disease Control, and the Venereal Disease Advisory Committee of The Medical Society of New Jersey.

3. One of the greatest concerns of the medical profession is funds supplied by the State to the local County Society for demonstration

programs or clinic services in which physicians who are especially qualified in venereal disease treatment are recommended by the County Medical Society to the local departments of health which engages them.

Venereal-Disease-Control Physicians. — Dr. Knight stated that in his experience there is no great problem involved in the application of the ways mentioned in the rural areas, because there are no specialists on venereal disease in these areas, and both the health administrator and individual doctors know one another well and work in harmony. The Medical Society's policy is merely to recommend competent venereal-disease-control physicians. The appointment of men in any clinic is the responsibility of those who run the clinic. State Health Departments, Civil Service qualifications may come in. The medical staff selects, but the Health Department appoints. There is no conflict in having the State Society recommend competent people. So long as the State Medical Society's power does not go beyond recommendation, there can be no objection to this procedure.

There is, of course, a fourth way in which venereal disease control work can be financed and that is by a local government using purely local funds to further its own program. Under these circumstances it can, of course, choose whom it likes to conduct the work. It is hoped that they will welcome the aid of the Medical Society in determining the qualifications of the available competent men.

Reporting Cases by Name.—The discussion on *reporting* cases of venereal disease as a communicable disease centered on the fact that it is desirable that the name and address be known to the Health Department in order that this communicable disease can be controlled through the supervision of the patient. Many physicians believe that the name of the patient should not be made a public record no matter how confidential the record may be kept as recorded in the State Health Department. Many places use a number and an address with good effect in maintaining control of these patients. The discussion brought out the fact that, although one obtains a name and reports it, it is more likely to be false and misleading than the true name. The name in the great majority of cases, when given by the patient at the clinic especially, is fictitious, and subject to change when the same patient visits another physician or another clinic.

Prophylaxis.—The recommendation of *prophylaxis* in the prevention of venereal diseases was unanimously endorsed by the Public Health Committee. With regard to the proposal to have the State Health Department furnish drugs free for all cases of venereal diseases, the Public Health Committee felt that this should be referred to Dr. Lewis' Committee on Medical Practice for opinion, and that the proposal should also be reviewed by Dr. Ulmer's Committee on Pharmaceutical Problems.

Payment for Drugs.—Dr. Teimer's proposal that no one should be denied treatment because of his inability to pay for drugs or service was endorsed.

All of these motions were unanimously approved. Regulations to be prepared to serve as a basis for the recommendation and approval of qualified medical men for venereal disease control clinics should be prepared by the special Advisory Venereal Disease Committee and should be similar to the Baby Keep-Well Station regulations for personnel. Unanimously approved.

The pertinent question was raised as to whether indigent patients who enter a hospital with an injury requiring surgical attention, and are found by the examining surgeon to be syphilitic should be entitled to free drugs supplied by the Health Department through the hospital.

Dr. Teimer stated his belief that, if a private hospital receives no governmental funds and operates not for a profit, the government should provide the necessary drugs to treat the syphilitic patient. If, however, the hospital is already a government institution, the question is academic, since the funds all come from taxation in such hospitals.

HUDSON COUNTY TUBERCULOSIS PROGRAM

Dr. Pollak and Dr. Jaffin described in some detail the Hudson County Tuberculosis program. Dr. Pollak stated it was a benefit to the people; and Dr. Jaffin emphasized the opportunity offered to the private practitioners to gain the necessary experience to take over this work as a part of their private practice.

Dr. Wilkes asked Dr. Jaffin if he knew of any figures available which showed the percentage of undiscovered tuberculosis detected in adults in the homes from which these Mantoux-positive children come. Dr. Jaffin stated that he knew of no such studies at this time, but that his program contemplated such studies in Hudson County. Three distinctive and different programs for early detection and cure of tuberculosis were described:

1. Hudson County plan (page 349).
2. Bergen County plan.
3. Middlesex County plan.

Dr. Kler stated that different plans and procedures in various places were desirable because of the variations in population concentration, and the available facilities for the work.

CANCER CONTROL

Dr. Orton was then asked to speak to the committee on the cancer problem. He described in some detail the *Curie Institute* of Newark, of which Drs. Orton, Danzis, Areson, and Martland are directors, along with three laymen. Dr. Orton discussed its aims, activities, funds and organization.

Dr. Nichols stated that some connection with the Medical Society would be desirable to insure the help of the physician in accomplishing the aims of the Curie Institute, and he thought that Dr. Kler and Dr. Orton should collaborate in the development of this work. Dr. Orton stated that all of the funds available to the Curie Institute remain in New Jersey for the benefit of cancer patients in this State.

Meeting adjourned at 5:30 p. m.

LEROY A. WILKES, M.D.,
Secretary.

TUBERCULIN TESTING OF HIGH SCHOOL STUDENTS IN JERSEY CITY

On April 21, Dr. B. S. Pollak, Director of the Hudson County Tuberculosis Hospital, and his associates, Drs. Immanuel Pyle, Abraham Jaffin, and Leonard B. Fauquer, began the work of testing the high school students of Jersey City for tuberculosis under the mass plan approved by the Welfare Committee of The Medical Society of New Jersey (Journal, February 1936, pp. 100 and 103, and April, p. 218).

Concerning the several plans which are in operation, Dr. Stanley Nichols, in his report to the Welfare Committee on March 1, 1936, reported to the Welfare Committee:

"A careful statistical evaluation of the results of tuberculosis testing in New Jersey shall be arrived at and its public health value more definitely determined; and that continued study of our efforts to solve this problem of tuberculosis control shall be made with the object of determining what efforts are really efficient and economical from a pubilc health viewpoints." (Jour., April 1936, p. 216.)

At the same meeting, Dr. T. K. Lewis, Chairman of the Sub-Committee on Medical Practice, reported:

"It (mass testing of high school students for tuberculosis) is a *public* matter rather than an individual one. * * * We therefore recommend the fullest coöperation of State and County Medical Societies with the Health Department and school officials in support of this measure." (Jour., April 1936, p. 218.)

The initiation of Dr. Pollak's work is described in the Jersey City Journal of April 12, which says:

"Approximately 3400 students at Henry Snyder High School who volunteered to take the test were lined up in the gymnasium this morning, and the first inoculation of tuberculin serum was given. Those who consented to take the test constitute 80 per cent of the enrollment of the school.

"Approximately 1800 students were inoculated this morning, and a new shift of six doctors set out this afternoon to inoculate the remaining 1400 at Henry Snyder High School. In addition to the students at the schools, teachers and others employed there volunteered for the test.

"Students who have a negative result from the test when they are examined Wednesday will be given another injection in the opposite arm, and will again be examined Friday.

"X-ray apparatus will be installed in the gymnasium on April 26, and x-rays will be taken of those who show a positive reaction.

"Nurses assisting this morning were from the Board of Education and the Hudson County Tuberculosis Clinic."

The doctors work in groups of six, with the assistance of eight nurses.

REPORT OF THE LUNG COMMISSION OF THE ESSEX COUNTY MEDICAL SOCIETY ON TUBERCULIN TESTING OF SCHOOL CHILDREN

Reported March 11, 1937. See Journal April, p. 297.

By Richard H. Dieffenbach, M.D., Chairman

Your commission notes with regret the introduction of mass tuberculin tests among the public school children of some of the larger municipalities of Essex County before facilities for roentgen raying the positive reactors were provided, and before the various agencies for treating the diseased children and for tracing sources of infection through contacts were coördinated.

The commission approves wholeheartedly this project, which aims:

1. To reveal open cases of tuberculosis in symptomless children who are sources of infection to others;
2. To detect early lesions demanding modification of school hours and studies;
3. To lead to the original sources of infection, often in adult members of the family.

Naturally, such an extensive study demands intelligent coöperation of private physicians and public health departments; and it should not be started until these agencies are prepared to assume their separate responsibilities for carrying out their functions efficiently. After considerable deliberation and discussion, we submit the following suggestions for your endorsement and approval.

This commission is in accord with the consensus of phthisiologists that *roentgen examination* of school children reacting strongly to the Mantoux test is an essential part of the survey. All other methods of examination are subordinate to roentgen pictures in determining the presence, type, and extent of pulmonary lesions.

Clinical examinations and laboratory tests will then offer further indications as to whether the patient has *quiescent and healing* lesions requiring only observation without changing the daily routine; or *slightly active* lesions requiring preventorium care; or *active lesions* necessitating sanitarium therapy.

This commission prefers transparent film to paper film. The paper films have the advantage of being cheaper and more time-saving when large groups are x-rayed at one time; but these advantages are outweighed by transparent film in better definition and gradation of pathological lesions, greater ease in interpretation of markings, and constant availability for small or large groups at all times.

No reliance is to be placed on fluoroscopy in a survey of this type.

The authority responsible for bearing the cost of x-ray service will vary in different-sized municipalities depending on population, school health service, public health services, presence and functions of county sanitaria, and other factors.

A school tuberculin survey is a *public health problem* in that it attempts to identify those who suffer from tuberculosis infection by means of intradermal injections of tuberculin, the cost of which is properly borne by public funds; it is a *private health problem* in that it indicates the possibility of the presence of tuberculous disease requiring examination by private physicians, the cost of which is rightfully the responsibility of the parents, except in indigent families. If part of, or all the cost of films is paid by public funds, this shall apply only to initial films used in the survey, and under no circumstances to future retakes in patients whose lesions require further study.

A more detailed plan proposed by the Radiological Section of the Essex County Medical Society was submitted to this society some time ago.

Detection of tuberculous infection in children by means of the tuberculin reaction is valuable, not only in the domain of *private health* by indicating those who require careful observation or treatment at a most important time, but also in the domain of *public health* by offering means to detect infectors by examining contacts of the positive reactors.

Teachers are examined by the medical officers of the school system. Tracing of contacts and education of parents as to the necessity for examining themselves and other members of the family are the functions of *public health departments* and allied organizations; but the examinations of contacts, be they dermal, clinical or roentgen, must be under the auspices of the *private physicians,* except, of course, among indigents.

This commission hopes all the organizations participating in this survey will function within the provisions of the above general principles.

Richard H. Dieffenbach.

PERIODIC LETTER TO MEMBERS—No. 4

Dear Doctor:

1. *The Annual Meeting* is almost at hand (April 27, 28, and 29), and everything is ready to receive you at Haddon Hall in Atlantic City.

a. *The Guest Speakers* are national authorities in their own fields, and a large variety are represented. Dr. Charles Gordon Heyd, President of the American Medical Association, will enlighten us as to the current thought in organized medicine. Dr. Thomas Parran, Surgeon General of the United States Public Health Service and President of the American Public Health Association, will acquaint us with the public health administrators' viewpoint. Dr. Howard W. Haggard, Yale University, is a true medical philosopher whose viewpoint is broad enough to see our own faults as well as our virtues. The list of speakers is contained in the program mailed to you on Friday, the 16th, and they will discuss internal medicine, surgery, chest conditions, maternal mortality problems, congenital abnormalities, and special problems in the fields of special interest represented in our sections.

b. *The Annual Reports* of the officers and committees were published in the April Journal. Every member should read these carefully; and then come to the Annual Meeting and hear them discussed, and the recommendations acted upon by the House of Delegates. The recommendations approved by the Delegates serves as a basis for the program of next year. It is urgent that *every Delegate* be present at the closing session of the House of Delegates on Thursday (at noon), at which time the program and budget for the succeeding administration will be determined.

c. After the House of Delegates has formally determined the program and policy of the State Medical Society for next year, your officers and committees will immediately begin to develop plans to put the program into action. Your executives will see that the plans are carried out as completely and rapidly as conditions permit.

d. *The dues* provide the budget and each member bears an equal share of the financial burden, but what each member gets out of his professional society is definitely proportional to the energy, thought, and coöperation which he puts into the program of his society. Suggestions and constructive criticism are invited and much appreciated, especially when these come from members who, through their active coöperation in the County and State Society, prove their loyalty and ability.

e. *Medical Practice in the future,* as in the past, will be determined by the demands made and the services offered to the public. The medical profession has always kept its services at hand ready for immediate delivery. Too many propagandists are endeavoring to "sell medical services out of a catalogue"; but the "services" they offer are not only not now available, but no arrangements have been made with the available trained and experienced personnel to deliver the services promised; and it is also true that no effort has been made to train and equip any other personnel for this purpose.

In Atlantic City we shall discuss these and many other questions. From the *practical* standpoint, New Jersey has taken the initiative in meeting economically and effectively the conditons faced as fast as convincing data are presented that such conditions exist and need medical help. Every member of our Society should keep abreast of these rapid developments which will largely determine the type of medical practice of the future.

f. *The Scientific and Business Meetings* will go on scheduled time, and the speeches and papers will be concise and stimulating.

g. *The Social Features* are offered for your entertainment and enjoyment. The hotel arrangements for your relaxation and comfort are unsurpassed anywhere in the world. Your friends will be there and are expecting you.

Now do *your* part!

h. *A special Greeting Committee* is on the outlook for the younger men and their wives to help them get acquainted with their colleagues. Come and stay the full three days or longer at "The World's Playground", Atlantic City, New Jersey, where the Oldest Medical Society in the U. S. A. is to hold its 171st Annual Meeting.

2. Three *recent publications* merit your study:

a. American Medicine (2 volumes)—recently published by the American Foundation for Studies in Government, 565 Fifth Avenue, New York City.

b. The Report of Eight Years' Study—by the Julius Rosenwald Fund of Chicago.

c. Report of The Symposium on Venereal Disease Work held in Washington, D. C., December 28-30, 1936—in the January, February, March issues of the Journal of Social Hygiene, 50 W. 50th Street, New York City.

3. Requests for the *"Handbook on Preventive Practice",* issued as a supplement to our March Journal, continue to pour in from medical schools, State and county medical societies, physicians in other states, and community agencies in New Jersey, who are becoming increasingly aware of the program and activities of The Medical Society of New Jersey.

4. The *new officers of the State Society* have attracted much interest and attention, and created increased respect for our profession. Visitors from other groups working in New Jersey and elsewhere comment enthusiastically upon the quarters, and upon the evidences of a definite program and organized effort.

5. The *P.-T. A.* is urging parents to have the *Summer Round-Up* examination done by the Family Physicians. Are you coöperating?

SPENCER T. SNEDECOR, M.D.,
President.

ANTI-PNEUMOCOCCIC SERUM

A bill has been introduced in the Legislature by Assemblyman Taggart of Atlantic City, making provision that the State shall supply anti-pneumococcic serum for types one and two of pneumonia. The bill was considered at a conference of a special committee of The Medical Society of New Jersey, with Dr. Mahaffey, Director of Health of New Jersey, and was approved in principle with modifications in details.

LIST OF PHYSICIANS DYING IN NEW JERSEY IN MARCH, 1937

Supplied by the State Department of Health

Name	Age	Date Death	Place of Death	Residence	Cause of Death
James Chasey	84	Mar. 29	West Long Branch	Same	Chronic myocarditis.
Charles F. Halstead	68	Mar. 8	Somerville	Same	Pulmonary embolism.
Thomas F. Higgins	58	Mar. 24	Gen. Hosp., Eliz'b'th	Elizabeth	Lobar pneumonia.
Otto E. Kopetschny	75	Mar. 23	Jersey City		Hodgkin's disease.
A. Haines Lippincott	69	Mar. 10	Camden	Same	Coronary artery occlusion.
Kirki Nagatsuka	62	Feb. 12	Ocean View	Same	Cerebral hemorrhage.
Frank L. Niles	53	Mar. 26	Wood Ridge	Same	———
William M. Rathgeber	40	Mar. 19	East Orange	Newark	———
Robert Rose	52	Mar. 19	Paterson	Same	Acute cardiac dilatation.
Edward B. Skellenger	85	Mar. 8	Trenton	Same	Chronic myocarditis.
Elizabeth T. Wright	65	Mar. 17	Atlantic City	Same	Cerebral hemorrhage.
Reuben Zimmerman	33	Mar. 9	Newark	Newark	Rheumatic heart disease.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS SINCE JULY 1, 1936

DIPHTHERIA TOXOID

County	To Mar. 31	Month of April	Total to Apr. 30	Average per Month
Atlantic	383	205	588	58.8
Bergen	1176	107	1283	128.3
Burlington	805	191	996	99.6
Camden	510	24	534	53.4
Cape May	99	82	181	18.1
Cumberland	261	21	282	28.2
Essex	9407	501	9908	990.8
Gloucester	161	4	165	16.5
Hudson	158	5	163	16.3
Hunterdon	106	0	106	10.6
Mercer	43	0	43	4.3
Middlesex	2423	34	2457	245.7
Monmouth	651	82	733	73.3
Morris	283	71	354	35.4
Ocean	301	57	358	35.8
Passaic	3509	521	4030	403.
Salem	55	15	70	7.
Somerset	1542	50	1592	159.2
Sussex	65	58	123	12.3
Union	908	100	1008	100.8
Warren	518	7	525	52.5
Totals	23364	2135	25499	2549.9

SMALLPOX VACCINE

County	To Mar. 31	Month of April	Total to Apr. 30	Average per Month
Atlantic	450	12	462	46.2
Bergen	991	26	1017	101.7
Burlington	230	0	230	23.
Camden	574	1	575	57.5
Cape May	60	1	61	6.1
Cumberland	384	51	435	43.5
Essex	4084	269	4353	435.3
Gloucester	314	3	317	31.7
Hudson	79	1	80	8.
Hunterdon	21	0	21	2.1
Mercer	77	1	78	7.8
Middlesex	633	12	645	64.5
Monmouth	1523	110	1633	163.3
Morris	882	126	1008	100.8
Ocean	257	4	261	26.1
Passaic	2018	77	2095	209.5
Salem	33	1	34	3.4
Somerset	40	23	63	6.3
Sussex	122	0	122	12.2
Union	1089	53	1142	114.2
Warren	591	2	593	59.3
Totals	14452	773	15225	1522.5

CONTACTS AND COMMENTS

COMING EVENTS

A. M. A. Meeting

The American Medical Association will hold its annual meeting in Atlantic City, June 4-11, 1937. All physicians of New Jersey are cordially invited to attend the sessions and to view the exhibits, provided they present cards certifying either that they are Fellows of the A. M. A. or are subscribers of one of the official journals that are published by the A. M. A.

There seems to be a misapprehension regarding the qualifications as a "Fellow". Every member of a State Medical Society is a member of the A. M. A. The number of representatives to which a State is entitled in the House of Delegates depends on the number of physicians on its official roll. Members of the A. M. A. do not pay dues, and yet they share the benefits offered by the A. M. A. except that of attending its formal meetings.

A member of the A. M. A. becomes a Fellow by subscribing to one of its official publications (which is the only "Dues" required), and at the same time being elected by the Trustees. A fellowship is denied to a member only on rare occasions, such as unprofessional conduct.

The Annual Meeting of The Medical Society of New Jersey had been set a month in advance of the usual time in order that it would not conflict with that of the A. M. A.

In 1934 New Jersey headed the list of all the State Societies in the proportion of its physicians who are either subscribers to an official A. M. A. Journal or Fellows. (Journal Med. Soc. of N. J., October 1934, p. 554.)

Dr. David B. Allman, Atlantic City, wishes to call attention to the annual meeting of the American Medical Association on June 7-11, 1937, and especially to four functions with which he is officially connected:

1. A dinner of the House of Delegates in the Renaissance Room of the Hotel Ambassador, on Monday, June 7, at 7 p. m.
2. A luncheon of the Medical Veterans of the World War Section of the Association of Military Surgeons of the United States, in the Hotel Ambassador, on Tuesday, June 8, at 1:00 p. m.
3. A luncheon of the Ex-Internes of the Atlantic City Hospital, at the Hotel Ambassador, on Wednesday, June 9, at 12:30 p. m.
4. A smoker of the Jefferson Medical College Alumni Association, in the Hotel Ambassador, in the Renaissance Room, and the Venetian Room on Wednesday, June 9, beginning at 9 p. m.

An all-day conference on Venereal Disease Control will be held in New Brunswick, on Tuesday, May 18, under the auspices of the New Jersey Health and Sanitary Association. Coöperating agencies include:

The Medical Society of New Jersey.
The State Department of Health.
The Health Officers' Association, Rutgers University.

Other organizations which touch the field of public health will also lend their influence.

An outline of the suggested program includes the following features:

10:00 a. m.—Showing the film, "Damaged Lives".
12:30 p. m.—Luncheon meeting in the Woodrow Wilson Hotel, on the subject, "A Practical Community Program".
2:30 p. m.—Group meetings.

1. FOR PHYSICIANS

Clinic demonstration of venereal disease diagnosis and treatment.

2. FOR HEALTH OFFICIALS

Problems of local municipal officials,—new clinics, prostitution prevention, etc.

3. FOR SOCIAL ORGANIZATIONS

Clinics in rural areas.
The Family Doctor.
School for investigators, nurses, etc.

4. POPULAR MAY DAY SESSION

Congenital syphilis.
Marriage.
Premarital medical examination.

8:00 p. m.—Rutgers University Chapel:
Lecture to the public—"The Drama of Syphilis".
Professor C. E. A. Winslow, Yale University.

The Committee on Public Health and Medical Education of the Academy of Medicine of Northern New Jersey will sponsor a lecture open to the public on Thursday, May 27th, at 8:45 p. m., at the Academy, 91 Lincoln Park, Newark. Dr. George Draper, Associate Professor of Clinical Medicine at Columbia University, will be the speaker. His subject will be "The Person in the Patient". Invite your friends to attend.

Medical Alumni
University of Pennsylvania
Alumni Day, June 5th, 1937
at the University.
Luncheon in the Quadrangle 12:30 P. M.
Parade 2:00 P. M.
Baseball Game with Princeton at
Franklin Field, 3:00 P. M.
Dinner at Cressbrook Farm, Valley Forge, Pa.
A. M. A. Convention, Atlantic City, N. J.
Smoker and Vaudeville
Wednesday, June 9th, 1937, Hotel Jefferson
Tickets available at Registration Booth

DR. SPROUL

Commenting on the presence of Dr. Joseph B. Harrison, of Westfield, at the Annual Meeting of The Medical Society of New Jersey for the sixty-first consecutive time (page 342), Dr. Edward J. Ill, Senior Fellow, recalled that when he first began to attend the annual meetings, Dr. Sproul, of Flemington, was always present, having attended fifty-three consecutive meetings. A search of the records of the former meetings shows that Dr. Obadiah H. Sproul was elected President of the State Society in 1894, and that he was Secretary of the Hunterdon County Medical Society for many years, before, during, and after his election as President of the State Society.

The Editor wishes to secure an account of the life and work of Dr. Sproul.

The April Bulletin of the Union County Medical Society carries the following "Personal Message" on the value of membership in the medical society of the county and State:

The future of medical practice can be assured only through solidarity, support, organized effort, teamwork, and sound leadership. These essentials should be provided within the ranks of the State and County Medical Societies. We now have good leadership, but we urgently need better understanding and teamwork, and the will to follow our leaders. We need also to enroll more members in order to get into the ranks of organized medicine every eligible physician in our State. A drive for increased members would be successful for it would be timely.

Achievement depends more upon our own understanding, our own teamwork, and our active support of our own programs than on any other factor. We have avoided, so far, most of the pitfalls, but further increase in number, organization, and support are essential to the preservation of our traditions and independence.

The new programs of the Medical Society committees, and the activities developed by their members in the last few years have increased our expenses, and if these important activities are to be continued we must have more funds. All County Society members should understand these aims, programs, activities, and achievements, and realize the need to increase our dues to carry on if the profession is to be recognized as the leader in health preservation and restoration in our State and communities. Failure to carry on means lost leadership.

We physicians consider a five-dollar bill a fair cost for an *evening's* entertainment—is it too much to pay for a *year* of increased opportunity and protection in your practice? We are asking each fellow member to think over this problem and be ready to support—or deny—the program prepared for carrying on our efforts under our new President in the year beginning immediately after our 171st Annual Meeting next month in Atlantic City.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

May				June			
4	Camden	14	Atlantic	8	Bergen	17	Morris
4	Hudson	19	Middlesex	8	Cumberland	23	Monmouth
11	Bergen	20	Gloucester	9	Mercer		Camden (Outing Meeting)
12	Mercer	26	Monmouth	10	Somerset		
12	Ocean		Salem (Social Meeting)	16	Middlesex		
13	Burlington						
13	Essex		Sussex (At call of President)		July		
13	Passaic			20	Warren	27	Hunterdon

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter



Certificates presented to Dr. H. B. Diverty and Dr. E. Z. Hillegas by the Gloucester County Medical Society for completing over fifty years of the practice of medicine.

DR. E. Z. HILLEGASS DR. H. B. DIVERTY

One short and stout, one tall and thin;
Each twinkling eye and gentle grin
Reveals a kindly heart within.

The regular monthly meeting of the *Medical Society of Gloucester County* was held on the evening of Thursday, April 15th, in the Homestead Coffee Shop, Woodbury, with 42 members and guests present, and President Lummis presiding. This was a dinner meeting in honor of two members who had practiced medicine for over half a century, Dr. E. Z. Hillegas, of Mantua, and Dr. H. B. Diverty, of Woodbury. The two are close friends and have lived in adjoining villages throughout the whole time of their practice. Since their lives were open books to practcally all the members of the county society, their careers were revicwed by the speakers with kindly humor that accentuated the friendly respect of their colleagues.

DR. E. Z. HILLEGAS

High points in the life of Dr. Hillegas were described by Dr. J. H. Underwood, of Woodbury.

Dr. Hillegas was deseended from an early Treasurer of the United States, and was born in Pennsburg, about twenty-five miles northwest of Philadelphia, in 1854. He graduated from the Philadelphia College of Pharmacy in 1874, and ran a drug store for a few years, always courteous and honest. He told one patron who asked for something to cure a cold, "Take this bottle of medicine; and if it does not cure you, come back and I will give you something that will."

Dr. Hillegas graduated from the Jefferson Medical College in 1880, and has practiced in Mantua



THOSE PRESENT AT THE SUPPER TABLE OF THE

1. J. Harris Underwood, Woodbury
2. Alfred G. Gillis, Clayton
3. Charles L. Fisler, Clayton
4. William Brewer, Woodbury
5. Oram Kline, Camden
6. Ralph Zapf, Wenonah
7. Chester I. Ulmer, Gibbstown
8. Isaac W. Knight, Pitman
9. Rev. Samuel Steinmetz, Trenton
10. Oran A. Wood, Paulsboro
11. LeRoy A. Wilkes, Trenton, Executive Officer, The Medical Society of New Jersey
12. Frank Overton, Trenton, Journal Editor
13. E. Z. Hillegas, Mantua
14. Marshall F. Lummis, Pitman
15. William W. Pedrick, Glassboro

for over half a century. He underwent two "Fatal" major operations, one for gall stones, and some years later, a resection of a foot of intestine for strangulated hernia. Now, at the age of 83, he is still in active practice as a beloved "Doctor of the Old School".

DR. HENRY B. DIVERTY

The life of Dr. Diverty was reviewed by Dr. Ralph K. Hollinshed, of Westville.

Dr. Henry B. Diverty was born in Dennisville, February 20, 1864, the son of a shipbuilder. He was educated in Hackettstown Seminary and Dickinson College, and graduated from Jefferson Medical College in 1887, and has practiced in Woodbury ever since.

Dr. Diverty has always taken life seriously, and yet kindly. He was superintendent of the Methodist Sunday School for seventeen years, and has served on the State Board of Medical Examiners for the last thirteen years. His current relaxation consists in attending the meetings of the medical societies of adjoining counties; but during recent years he has closed his office in June and travelled the world over until October.

Dr. Diverty has been Reporter of the Gloucester County Society for over twenty years, and has a perfect score for mailing a report to The Journal on the day after each meeting.

Dr. William Brewer, of Woodbury, presented Drs. Hillegas and Diverty with engrossed certificates in honor of their fifty years in the practice of medicine.

Dr. H. L. Sinexon, of Paulsboro, led in the singing of popular songs, and also sang two classic solos. The program closed with an inspirational address by the Rev. Samuel Steinmetz of St. Michael's Episcopal Church, Trenton.

The following members were present: Drs. M. F. Lummis, E. Z. Hillegass, H. B. Diverty, C. I. Ulmer, Oran A. Wood, R. D. Zapf, William Brewer, Louis Ruttenberg, R. K. Hollinshed, Harry Nelson, Paul M. Pegau, William E. Crain, I. W. Knight, A. G. Gillis, C. F. Fisler, B. A. Livengood, C. C. Sheets, H. L. Sinexon, William Pedrick, Dorothy Rogers, Ralph D. Moore, J. F. Hughes, Edwin Ristine, F. G. Sherman, W. J. Burkett, W. H. Carpenter, H. M. Fooder, Gilbert Palen, Don Weems, J. Harris Underwood, E. E. Downs.

Visitors included Drs. Emma Richardson, Oram Kline, Thomas Kain and Thomas Lee, of the Camden County Society.

From the State Society were: Dr. W. J. Carrington, First Vice-President; Dr. LeRoy A. Wilkes, Executive Officer, and Dr. Frank Overton, Editor. Dr. Carrington sprang a surprise by reading a number of newspaper headlines setting forth the social unrest in lurid terms, and then giving the information that every headline was from the newspapers of 1887.



GLOUCESTER COUNTY MEDICAL SOCIETY, APRIL 15, 1937

16. Ralph K. Hollinshed, Westville
17. Emma Richardson, Camden
18. Henry B. Diverty, Woodbury
19. Cecil C. Sheets, Paulsboro
20. Horace M. Fooder, Williamstown
21. Elwood E. Downs, Woodbury
22. Paul M. Pegau, Woodbury
23. Howard F. Palm, Camden
24. Thomas B. Lee, Camden
25. J. Russell Butler, Woodbury
26. Henry L. Sinexon, Paulsboro
27. Charles C. Wolferth, Philadelphia
28. Thomas M. Kain, Camden, son-in-law of Dr. Hillegas
29. William Carpenter, Woodbury
30. Wendell Burkett, Pitman
31. Harry Nelson, Woodbury
32. James H. Underwood, Woodbury

Additional doctors arriving later:

Louis Ruttenberg, Mantua
William E. Crain, Woodbury
B. A. Livengood, Swedesboro
Dorothy Rogers, Woodbury
Ralph L. Moore, Woodbury
Edwin R. Ristine, Camden
F. G. Sherman, Woodbury
Gilbert Palen, Woodbury
Don Weems, Wenonah
William J. Carrington, Atlantic City, First Vice-President of The Medical Society of New Jersey

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ATLANTIC COUNTY

E. H. Nickman, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held Friday, April 9th, 1937, at the Ambassador Hotel, President Dr. J. S. Irvin presiding. Fifty-eight members and guests were present.

NEW MEMBERS

Drs. Harris, Bedall and Marshall were unanimously elected to membership in the society upon recommendation of the Board of Censors.

CHILD HYGIENE

A motion was passed that Dr. Bedall (who has been working in an unofficial capacity in the Baby Keep-Well Station in Minetola) be recommended for that position by the society.

Dr. Brown stated that throughout the State the Maternal Welfare Committee had carried out round table discussions of obstetrical problems, and suggested that such a program would be of benefit in Atlantic City.

HAY FEVER CONTROL

Dr. Hyman reported that the Committee for *Hay Fever Control* had received the coöperation of the municipalities on Absecon Island, and Brigantine, and that a request would be made of mainland cities to coöperate also. He suggested that a part of the regular weekly broadcasts might be devoted to bringing this work before the public.

PUBLIC HEALTH HOUR

Dr. Kline reported that the City Hall Clinic had been opened a short time, and that Dr. Salasin would close it if the physicians of Atlantic City would do the work in the Public Health Hour. He suggested that lists of the doctors doing this work

should be given to Parent-Teacher Associations and other organizations doing social service work.

ANNUAL MEETING OF STATE SOCIETY

Dr. Kaighn stated that the program of the Convention of the State Society was to be one of the most interesting ever presented; and also said that the banquet was the only affair for which the members were asked to pay anything, and he urged that every member plan to attend. Dr. Blampin was appointed to take charge of the tickets.

Dr. Allman urged all delegates to the State Society to attend all business meetings, since in this way only can voice of our county society be heard. He felt that delegates who cannot or do not attend the meetings should not accept the offices as delegates.

MEMORIAL TO DR. E. H. HARVEY

Dr. Brown presented a resolution to be incorporated in these minutes upon the death of Dr. E. H. Harvey.

A note of thanks was received from R. A. Kilduffe, M.D., for the flowers sent while he was in Temple University Hospital.

Dr. Allman explained the difference between members of the A. M. A., and fellows of the A. M. A. (A member of a county medical society is also a *member* of the A. M. A., but is not a Fellow unless he has subscribed to one of the journals of the society, and has been approved as a Fellow by the Trustees of the A. M. A.—*Editor's note.*)

NOMINATING COMMITTEE

As the May meeting is the Annual Meeting, at which the election of new officers of this society takes place, the following Nominating Committee was appointed: Dr. D. W. Scanlon, Chairman; Drs. K. M. Scott, Carl Surran, S. Barbash, C. M. Fish.

SCIENTIFIC

The scientific program of the evening was presented by Dr. Francis R. Packard, of Philadelphia, who gave a most interesting address on "Early Case Records at the Pennsylvania Hospital". Dr. Packard presented the highlights in the life of Dr. Philip Sing Physick and his work in surgery from case records.

BERGEN COUNTY

LeRoy W. Black, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held at the Hackensack Hospital on Tuesday, April 13th, Dr. J. H. Irwin, our President, presiding.

MEDICAL-DENTAL SERVICE BUREAU

The Executive Committee had approved of a loan of seven hundred dollars ($700.00) to the Bergen-Passaic Medical Dental Service Bureau. This action was approved.

NOMINATIONS

The Nominating Committee submitted the names for officers for next year, to be submitted to the Annual Meeting in May.

POST-GRADUATE COURSE

Dr. G. Barton Barlow reported the conclusion of a successful Post-Graduate Course. He stated that mimeographed copies of the lectures would be sent to those who had taken the course. The society voted thanks to Dr. Barlow and his committee.

NEW MEMBERS

The following were elected to membership:
To Regular: Dr. Francis J. Fadden, Englewood
From Junior to Regular: Dr. Theodore R. Miller, Hackensack
To Junior: Dr. A. R. Jenkins, Englewood

DUES

Dr. S. T. Snedecor, President of The Medical Society of New Jersey, spoke upon the activities of the State Medical Society, indicating the need for increasing the dues, and showing how the doctors would gain thereby.

SCIENTIFIC

Dr. George J. Heuer, Director of Surgery, Cornell University, spoke upon the "Errors in the Diagnosis of Acute Abdominal Conditions". Dr. Heuer gave very interesting mortality statistics on cases that he had treated in Cincinnati and New York. The conditions he cited were appendicitis, gallbladder dsease, and ruptured gastric ulcer.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was held April 6th, 1937, at 9 p. m. at the Cooper Hospital, Dr. B. F. Buzby presiding as President, and ninety-two members present.

ATHLETICS

The society moved that the "society condemn the program for compulsory competitive interscholastic athletics in high schools for girls from twelve to eighteen years of age".

DUES

The question of the possibility of an increase in the annual dues to the State Society was discussed. The delegates were instructed how to vote.

SCIENTIFIC

It being case night, the following cases were given:

1. Three Cases of Giant Tumor—J. E. Roberts, Jr., M.D.
2. Molluscum Contagiosum of the Eyelid—William Braun, M.D.
3. A Treatment for Impetigo Contagiosa—Robert Imhoff, M.D.
4. Obstruction of the Gastro-Intestinal Tract with Illustrative Cases—Paul M. Mecray, M.D.
5. Bilateral Ovarian Cyst in a Seventeen-Year-Old Girl—E. A. Y. Schellenger, M.D.
6. A Few Remarks on Coronary Artery Disease—R. K. Hollinshed, M.D.

A supper was served after the meeting in the nurses' dining room.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

On April 13th, Ivy Manor drew the largest attendance of the *Cumberland County Medical Society* at the annual meeting for many years—forty-four members and several visitors.

The entire session was occupied by the transaction of business, closing the last fiscal year of the society, and making plans for the coming year. The activities of the society cover a broader field each year, in practicing preventive medicine.

The annual election of officers resulted in the choice of the following:

President, L. E. Myatt
Vice-President, Dave Woodruff
Secretary, H. S. Branin
Treasurer, H. H. Wilson
Reporter, E. S. Corson
Censor, Charles Sharp

Executive Committee: H. E. Lore, F. M. Ramsey, J. F. Reeves.

Delegate to State Society: H. Garrett Miller

State Nominating Committee: Delegate, L. E. Myatt; Alternate, E. C. Lyons

Dinner was served in the dining room.

The spacious dining room was filled and evidence of good fellowship and enjoyment of the delicious dinner was prevalent.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

A regular meeting of the *Essex County Medical Society* was held Thursday evening, April 8th, 1937, at the Academy of Medicine, Newark. The President of the Society, Dr. Edgar A. Ill, was called away shortly after the start of the meeting. In his stead First Vice-President Dr. H. Roy Van Ness presided throughout the evening.

WORKMEN'S COMPENSATION

The scientific program was under the direction of the Committee on Compensation Laws, J. Irving Fort, M.D., Chairman.

The speaker of the evening was David J. Kaliski, M.D., of New York City, who spoke on "The Management of the Compensation Laws and Activities in New York. Dr. Kaliski is Chairman of the Workmen's Compensation Board of New York State, Past President of the Medical Society of the County of New York, Chairman of the State Society Committee on Compensation Laws, also Chairman of the Coördinating Council of the five metropolitan county medical societies. He described the provisions and modus operandi of the New York Compensation Laws, under which organized medicine has assumed responsibility for the quality of the medical service to injured workmen and for the conduct of physicians.

The address was discussed by Dr. J. Irving Fort, Chairman of our State Committee on Compensation Laws, and Dr. Maurice Avidan, on the local operation of our law.

ENDORSEMENT FOR CITY OFFICE

An action of the Executive Council urging its President, Dr. Edgar A. Ill, to become a candidate for Commissioner of the City of Newark came before the society for endorsement. This provoked a spirited discussion. Several members opposed and others favored any significant action pertinent to a local election.

ETHICS

Changes in the By-Laws were adopted describing certain phases of unethical conduct for which members might be subject to disciplinary action. The points referred to are publicity in lay publications, improper court testimony, and case-lifting. Any member whose professional abilities or acts shall be referred to in any newspaper or non-medical magazine or periodical may be liable. Giving of improper testimony in court was described as exaggeraton or minimization of injuries, or of statements of substantal untruths. "Case lifting" was defined as persuading a patient to transfer from one doctor's care to another's.

REGISTRATION AND DUES

A communication from a physicians' club was read opposing annual registration of physicians, favoring the allocation of funds collected as dues for the persecution of illegal practitioners in lieu of fees collected by annual registration. They also expressed their opinion about state reciprocity of the right to practice medicine.

The following new members were elected:

Regular Membership:

Horace Orlando Bell, 541 Page Ave., Lyndhurst
Lewis A. Brodkin, Newark City Hospital, Newark
Frank Burstein, 402 Clinton Ave., Newark
Joseph A. Clinton, 315 Park Ave., Newark
James J. Longo, 211 Stewart Ave., Arlington
John F. Kearney, 228 Hilton Ave., Maplewood
Marvin T. Richardson, 4 Sherbrook Parkway, Livingston
Frederick Strauss, 777 So. 20th St., Newark
Adolph Wegrocki, 186 Warwick St., Newark

Reinstatement:

Rose D. Bass, 222 Lyons Ave., Newark
Albion C. Christian, 1080 Clinton Ave., Irvington

Associate:

Irving Orcherct, 334 Central Ave., Orange
John S. Giardina, 47 Wyoming Ave., South Orange
Orlando Caprio, 66 Stone St., Newark

HUDSON COUNTY

John N. Connell, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held at the Carteret Club, Tuesday, April 6th, 1937, and was called to order at 9:20 p. m. by the President, Dr. J. L. Evans, who introduced as guests the following officers of the State Society: Dr. William G. Harrison, President-Elect; Dr. LeRoy A. Wilkes, Executive Officer; and Dr. J.

Irving Frost, Chairman, Workmen's Compensation Committee.

Bills were audited and four physicians were proposed for membership.

NEW MEMBERS

The following new members were elected:

Dr. Benjamin P. Abrams, 919 Washington St., Hoboken
Dr. Dante P. Crisonino, 12 West 41st St., Bayonne
Dr. John J. Danielson, 977 Bergen Turnpike, North Bergen
Dr. J. D. Goldstein, 2801 Boulevard, Jersey City
Dr. John T. Higgins, 145 Highland Ave., Jersey City
Dr. Thomas F. Lane, 155 Garrison Ave., Jersey City
Dr. John J. Mackin, 596 Bergen Ave., Jersey City
Dr. Michele Tomaiuoli, 70 32nd St., North Bergen

By transfer from Orange County Medical Society, New York, to Hudson County Medical Society: Dr. Maurice Kamp, 646 Palisade Ave., West New York.

Regularly moved and seconded the Secretary cast one vote. So ordered!

NOMINATING COMMITTEE

The following were chosen to serve in 1938:

Dr. J. A Botti — Dr. A. J. Conty
Dr. W. T. Callery — Dr. E. J. Daly
Dr. C. J. Larkey

DUES IN STATE SOCIETY

Dr. J. F. Londrigan introduced the following resolution:

Whereas, the dues assessed against the members of The Medical Society of New Jersey are considered by many to be excessive; and

Whereas, as this particularly concerns Hudson County, $13.00 of every $18.00 being given over to the State Society; therefore

Be it resolved, That the Delegates of the Hudson County Medical Society to the next State Convention be now instructed to make diligent inquiry of the President, Executive Officer, and the Secretary of The Medical Society of New Jersey, concerning the finances, salaries, expenditure and general budgeting of The Medical Society of New Jersey with a view of effecting some economies in the management of the State Society which would reflect themselves in a reduction of the State Society assessment of $13.00.

This resolution was adopted.

SCIENTIFIC SESSION

The program of the scientific session was a symposium on cancer. The first speakers was Dr. Fred H. Stewart, Pathologist at Memorial Hospital, New York, whose subject was "Recent experimental Approaches to Causation of Tumors".

Discussors: Drs. Alter, Braunstein, Elsasser. Concluded by Dr. Stewart.

Dr. William P. Healy, Professor of Gynecology at Polyclinic Hospital and Memorial Hospital, New York, spoke on "The Use and Misuse of Radiation in Cancer of Uterus".

Discussors: Drs. Waters, Ballinger, Swiney, Perlberg. Concluded by Dr. Healy and Dr. J. H. Rosecrans.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met in the New Jersey State Hospital, in Trenton, on the evening of Wednesday, April 14th, with President D'Arcy presiding.

SCIENTIFIC

The program of the scientific part of the meeting consisted of a clinical demonstration of psychiatric patients under the direction of Dr. J. B. Spradley, Assistant Director of the institution, assisted by Drs. Miller, Hawke, Magee, and Davis of the medical staff. The group presented patients with dementia praecox, post-encaphalitis, cerebro and spinal syphilis, and explained their history, progress, and prognosis. The demonstration was in line with the recommendation contained in the annual report of the Committee on Mental Hygiene (Journal, March, p. 266).

Dr. R. G. Stone, Superintendent of the hospital, described the methods of caring for the patients, showing the large percentage of admissions that are voluntary—about 30 per cent; and a high percentage of cures—59 per cent—classifying as cured, those patients who are able to go back to their homes, and who have no remissions for at least one year.

Dr. Stone also described the treatment of physical conditions of the patients. A resident physician is assigned to each specialty—gynecology, surgery, ophthalmology, etc.,—and all possible treatments, both medical and surgical, are given The hospital is, in fact, a general hospital in addition to its own specialty of psychiatry.

MEDICAL SOCIETY DUES

Dr. North referred to the possible increase in the dues of the State Society, and suggested that the Delegates from Mercer County to the State Society be instructed to support the budget which is suggested by the Finance Committee. A motion to this effect was unanimously adopted.

NEW MEMBERS

Drs. Charles E. Clark, Sydney Lavine, and Charles W. Miller, Jr., were elected to active membership, and Drs. John A. Stabile and Marta Vol Tretter, to associate membership.

Adjournment.

MONMOUTH COUNTY

O. R. Holters, M.D., Reporter

REPORT OF EXECUTIVE COMMITTEE

A meeting of the Executive Committee of the *Monmouth County Medical Society* was held on Monday evening, March 8th, at the Fitkin Memorial Hospital. Those present were Drs. Rullman, Perry, Watkins, Kazmann, Pregnall, Nichols, Fairbanks, Clayton, MacKenzie, and Featherston.

COMMITTEE CHAIRMEN

Dr. Stanley Nichols, Chairman of the Public Health Committee, announced the appointments of the following chairmen to serve on the sub-com-

mittees. Each chairman has the power to select his own committee members.

Robert MacKenzie, Maternal Welfare
Robert E. Watkins, Child Health
C. Byron Blaisdell, Venereal Disease Control
Otto R. Holters, Cancer Control
Warren Fairbanks, Tuberculosis Control
Berkeley Gordon, Mental Hygiene
Barclay Moffatt, Crippled Children
Samuel Edelson, School Health
L. F. Albright, Adult Health Supervision

FIELD PHYSICIAN

Dr. Mackenzie reported that the position of Field Physician in this territory, under the State Maternal Welfare program, was vacant. He suggested that Dr. William Hearley, of Red Bank, serve in this capacity.

FEE FOR MENTAL EXAMINATIONS

The following resolution was adopted by the Monmouth County Board of Freeholders at a meeting held on February 17th, 1937:

Be it resolved, by the Board of Chosen Freeholders of the County of Monmouth, that no bills for the examination of any patients committed to the State Hospital of the State of New Jersey, or any other State institution, will be accepted by this Board for payment, unless the said examination shall have been authorized by any one of the following county officials, viz: County Adjuster, County Physician, County Judge, County Prosecutor, or Sheriff of the County of Monmouth.

And be it further resolved, That the charge should not exceed the sum of five ($5.00) dollars for such examination.

(The above resolution was offered by Mr. Woolley and seconded by Mr. Murphy, and adopted on roll call by the following vote: Affirmative, Messrs. Murphy, Parkes, Woolley, and Director Wyckoff; negative, none. Absent, Mr. Mayer.)

This matter has been under discussion by the Medical Society for a long time, and it was again referred to the Economic Committee with the suggestion that another conference be held with the Board of Freeholders in an effort to convince them that the fee is inadequate for the amount of work and time involved. The result of this meeting will determine the stand to be taken by the Medical Society.

The minutes of the Health and Welfare Committee of the Monmouth County Organization for Social Service were read, and particular attention was paid to the report of the Committee on Venereal Disease Campaign. The Secretary was instructed to notify the organization that we object to the title "Welfare Clinic", and that these clinics should be known as Venereal Disease Clinics. In the report it was also stated that "patients treated at these clinics are supposed to be indigent or semi-indigent". The Executive Committee feels that only indigent patients should be treated at the clinics.

CHECKING DISPENSARY ADMISSIONS

A letter was received from Miss Walker, Director of Public Health and Welfare Department of the Monmouth County Social Service Organization, in regard to a method of investigating and checking dispensary admissions to the Monmouth Memorial and Fitkin Memorial Hospitals. The plan was discussed, and on motion by Dr. Parry, the matter was referred to the Economic Committee for further study.

It was suggested to the Economic Committee that dispensary cases be admitted only upon receipt of a written request from a practicing physician in Monmouth County.

The possibility of raising the dues of the Medical Society was suggested, in order to employ a social service investigator in each hospital to check the clinics and out-patients departments. It is felt that this would ultimately benefit the doctors.

HEALTH INSURANCE LEGISLATION

The following letter was received from the State Medical Society:

"A letter received from Dr. Joseph Lawrence, Executive Officer of the New York State Medical Society, states that he has been informed that Senator Wagner has written to certain lay groups in New Jersey a letter requesting their agitation for and support of a bill for national health insurance legislation in Washington.

"To date we have heard nothing of such a letter, but are requesting our officers in both the State and County Medical Societies to be on the alert to learn of any actvity on the part of Senator Wagner, and if possible to get copies of any letter having such a purpose in view, which has been received by any lay agency in New Jersey.

"If any such evidence is obtained, please communicate at once with the Executive Officer in Trenton by telephone (Trenton 9330) and reverse the charges."

TUBERCULIN TESTING

Dr. Stanley Nichols read a letter from the Monmouth County Organization for Social Service outlining a plan for a test experiment to be put into operation in the Manasquan High School. The program is to give 470 students the Mantoux tuberculin test, followed by an x-ray at the Allenwood Sanatorium for those who have a positive reaction. Since this project does not consider the economic phase, the matter was referred to the sub-committee on tuberculosis, and Dr. W. G. Herrman for further discussion and study before presenting it to the Medical Society for acceptance.

VENEREAL DISEASES

The clinics have begun to operate, and for indigent cases only. Refer to these clinics any cases in whom you are interested, but who cannot afford to come to you.

On basis of known averages, eleven thousand cases of unsuspected syphilis probably exist in Monmouth County! Take Wassermanns!

The regular monthly meeting of the *Monmouth County Medical Society* was held on Wednesday evening, March 24th, at 8:30 p.m., at the Berkeley-Carteret Hotel in Asbury Park, with an unusually

large attendance, with Dr. O. K. Parry, Vice-President, in the chair.

There was considerable discussion about the proposed survey by the Monmouth County Social Service Organization of the pupils at the Manasquan Hight School. It is proposed that this organization have a routine Mantoux test performed and also a chest x-ray of each pupil.

Further consideration has been given this matter by the County Medical Society, and a threefold plan is to be submitted to the Social Service Organization by a committee of the County Society.

EUGENIC STERILIZATION

A communication was read from the New Jersey League of Women Voters in which they inquired how the Society stood on the matter of eugenic sterilization. It was moved and seconded that the matter be referred to the State Welfare Committee for advice.

HYGIENE CONFERENCE

The Monmouth County Social Hygiene Conference, under the auspices of the county-wide Committee on Venereal Disease Control, will meet on Thursday, April 1st, at the Hotel Berkeley-Carteret in Asbury Park.

SCIENTIFIC

The paper of the evening was entitled "Medical Progress by Evolution or Revolution?", which was read by Dr. T. K. Lewis, of Camden, N. J. It described the progress of the practice of medicine and surgery up to the present time; and he also discussed the various economic and social problems that confront organized medicine today. A suggested program for the medical profession was given.

The paper provoked so much discussion by Dr. Blaisdell, Dr. Nichols, and others, that it was midnight before the society adjourned.

MIDDLESEX COUNTY

Charles H. Calvin, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on Wednesday evening, April 21st, 1937, at "The Pines", and was called to order by the President, John H. Rowland, M.D.

SCIENTIFIC

Dr. J. H. Kler, Chairman of the County Committee on Cancer Control, presented lantern slides showing the cancer statistics of Middlesex County. He showed cancer ranking sixth in 1905 and second in 1935 as the cause of death in New Jersey. This increase may be due to several causes:

a. Better diagnosis by all physicians whose cases were formerly undiagnosed.

b. Life expectancy of new born has increased.

c. Death from other diseases during middle age is less, and so people live to be of older age.

Dr. Kler introduced the speaker of the evening, Dr. George T. Pack, Surgeon at Memorial Hospital, New York City. His subject was "Recent Advances in Cancer Research". Dr. Pack described the lines of experimenting for the purpose of discovering the etiology and control of cancer.

Dr. Ely, Past President of The Medical Society of New Jersey, gave a short address on "What Shall We Do and How Shall We Take Care of the Cancer Problem in New Jersey?"

LIST OF SPEAKERS

Dr. Sherman, Chairman Public Relations Committee, gave a condensed resumé of the recent activities of his committee. He stated four more speakers were added to the speakers' list.

NEW MEMBER

Dr. Joseph A. Smith, at present on the staff of the Roosevelt Hospital, was unanimously elected to Associate Membership.

TUBERCULIN TESTS

Dr. Sherman, Chairman Public Relations Committee, reported on several newspaper articles by Dr. White, of the Roosevelt Hospital, in which he opposed the present arrangement of the County Society by which the family physician administered the tuberculin tests, and said that they should all be done at the tuberculous clinics. A committee was appointed consisting of Drs. Kler, Chairman; Avery, William Klein, London, and Sherman to interview Dr. White as to the correctness of these articles and report their findings at the next meeting.

The meeting adjourned for refreshments.

MORRIS COUNTY

A recreational and semi-scientific meeting of the *Morris County Medical Society* was held the evening of April 15th, 1937, at Spring Brook Country Club in Morristown.

President Sherman called the meeting to order with about 140 members and guests present.

Dr. Raymond L. Ditmars, Curator, New York Zoölogical Park, was the guest of the evening and spoke on the subject "Evolution in the Reptile Kingdom", illustrating his lecture with close-up motion pictures. The harmless and dangerous species of snakes were differentiated, as were the venom toxicities of the various species. Some species are valuable because of their devouring destruction of rodents, which if not checked would be potential for extreme damage and death-dealing plagues.

A demonstration was given with a live snake of the technic of extracting venom to be used in antitoxicity treatments for snake bites, and explaining the methods of treatment; also holding out the hope that in time some of these venomous extracts may be used in combating malignant growths in humans. Emergency measures in treating snake bite were demonstrated, and treatment instruments were exhibited and explained.

While Dr. Ditmars' lecture and pictures primarily covered the subject of snakes, of collateral interest was the showing in combat of the snake's enemy, the mongoose.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on Thursday, April 8th, 1937, at the Health Center, Paterson, at 9 p. m., Dr. Norman Dingman, President, in the chair.

NEW MEMBERS

The following applications for membership, having been approved by the Board of Censors, were acted upon favorably:

Dr. Michael Liebson, 120 Van Houten Ave., Passaic
Dr. Philip Noto, 158 Washington Pl., Passaic
Dr. Fred J. Schwartzberg, 377 East 33rd st., Paterson
Dr. James Irragi, 79 Broadway, Passaic

MEMBER NOMINATING COMMITTEE

A motion was made by Dr. Ash that the President appoint a member to the State Nominating Committee. The motion was seconded by Dr. Graham and unanimously approved. Dr. Dingman then appointed Dr. Wright MacMillan as our member of the State Nominating Committee.

EUGENIC STERILIZATION

Dr. Dingman then announced that a request had been received from the Non-Partizan League of Women Voters that endorsement of a bill now pending in the New Jersey Legislature, regarding compulsory sterilization of the feeble-minded and epileptics be given by the Passaic County Medical Society. After considerable discussion, Dr. Yates, seconded by Dr. Roemer, moved that the President appoint a committee to thoroughly investigate this bill and report back to the Society for action at a later date. This was unanimously adopted.

OSTEOPATH PRACTICING MEDICINE

Dr. Cogan introduced the following motion:

Resolved, That the Secretary communicate with the President of the New Jersey State Medical Society requesting him to direct its attorney to look up a decision of the Court of Errors and Appeals made on or about October 16, 1928, in the case of State vs. Comitis De Young, of Paterson, and to send a copy of this decision to the Passaic County Medical Society. (See this Journal, May, 1928, page 385.)

The motion was seconded by Dr. Ash and unanimously adopted.

SCIENTIFIC

Dr. Dingman then introduced the speaker of the evening, Dr. Allan DeForest Smith, Attending Surgeon, New York Orthopedic Hospital, New York, who spoke on "Acute Joint Infections".

Dr. Smith gave an excellent paper on the subject, and stressed the excellent results from early operative drainage of these acute joint infections.

The paper was discussed by a number present, and the meeting was then adjourned.

SALEM COUNTY

L. C. Hummel, M.D., Reporter

The regular meeting of the Salem County Medical Society was held Friday evening, April 8th, at 9 p. m. in the Salem Hospital, Dr. J. S. Dunn presiding.

MEMBERSHIP DRIVE

There are several physicians in our county who do not belong to the society, and ways and means of getting them to join were very thoroughly discussed. It was finally decided to change the time of our meetings to 3 p. m. instead of 9 p. m.; and to rotate the place of meeting between Pennsgrove, Woodstown, and Salem. Starting in October, following the Summer recess, the meetings will be monthly instead of bi-monthly. The place of meeting will be left to the discretion of the Program Committee.

ELECTION OF OFFICERS

This meeting was our regular time for reorganization, and the following were elected to office:

President, Dr. C. B. Mackes
Vice-President, Dr. H. F. Suter
Secretary and Treasurer, Dr. J. S. Dunn
Reporter, Dr. L. C. Hummel
Member of Credentials Committee, Dr. W. H. James
Delegate to State Society for three years, Dr. W. H. James
Member of Nominating Committee, Dr. D. W. Green
Alternates to State Society: Drs. Perry, Flaning, and Hummel
Alternate for Nominating Committee, Dr. J. S. Dunn

SOCIAL MEETING

A motion to have our annual shad dinner on May 5th at the Salem Country Club was unanimously passed.

Following the meeting a lunch was served in the hospital dining room.

UNION COUNTY

C. C. Carpenter, M.D., Reporter

The regular meeting of the *Union County Medical Society* was held April 14th, 1937, at Overlook Hospital in Summit, N. J., with the President, Dr. Elmer P. Weigel, presiding.

MEMBER OF BOARD OF HEALTH

There was a lengthy discussion as to the method of appointing new men to the Elizabeth Board of Health. This was entered into by Drs. Walsh, Burritt, Carpenter, Murphy, and Capps, and at the suggestion of the society, Dr. Wiegel appointed a committee of Drs. Walsh, Lehrman and Burritt to meet with the Elizabeth Board of Health members to make satisfactory arrangements.

MEDICAL-DENTAL SERVICE BUREAU

Dr. Thomas Walsh reported that in the past two months the bureau has been self-supporting, and that the receipts have been over $100.00 greater than the expenses of maintenance. It is also indicated that in April they will even further exceed the past two months. Undoubtedly, the Summer months will be slower. This report was extremely encouraging in view of the difficulties we have had in the past six months.

NEW AND DELINQUENT MEMBERS

Dr. Morris reported that the committee had made a partial survey of the county and found that 90 per cent of the doctors resident here were members of our medical society. He suggested that a more liberal policy be established to delinquent members, and that they only be required to pay one year's back dues to obtain reinstatement. The good work of this committee will be continued until Fall, with a more complete survey of the bigger cities in this county.

CONSUMERS CO-OPERATIVE MOVEMENT

Dr. Robert Miller, of Summit, introduced for discussion the Consumers' Coöperative Movement. This is spreading quite rapidly in some of the smaller communities throughout our county. It was suggested that a committee be formed to investigate this carefully, but that no member should serve in a professional capacity to this organization until the committee has given its approval. Dr. Wiegel appointed Dr. Watson B. Morris, Dr. Robert Miller, Dr. Henry Able, and Dr. S. Davis to study this movement and report at our next meeting in the Fall.

SCIENTIFIC

The speaker for the evening was Dr. Stewart Z. Hawks, of the Newark Presbyterian Hospital, who gave an excellent presentation of diagnosis and treatment of *varicose veins,* with special emphasis on the technic of high ligation of the internal saphenous. He pointed out that this step is extremely important in many cases to prevent recanilization of the thrombi that have been formed by the injections.

REPORT OF PUBLIC HEALTH COMMITTEE

Dr. Cassilli has reported on Cancer Control:

"That a properly organized and conducted tumor clinic be established in at least one hospital. The clinic should have adequate radio-therapeutic equipment, including low, medium, and high voltage x-ray machines, and a minimum of 150 mgs. of radium.

"The tumor clinic should be organized and directed by a specialist in oncology; i. e., a physician who has had special training for three or more years in a tumor hospital, such as the Memorial Hospital of New York City. In addition to the director, there should be recruited from the hospital staff a clinical consultation group, a radiologist, and a pathologist. The clinic should be a source of education to the general practitioner, by means of clinical conferences and other methods.

"The consultation staff of the clinic should render expert service in diagnosis and treatment of any patient sent by any physician in the county. The patient should always be sent back to the referring physician with the diagnosis and recommendations for treatment. The physician is thus given free choice of referring the patient either to the clinic or to a private radiologist for treatment."

Dr. Runnells reports for the Tuberculosis Committee. The work of the Mantoux test is rapidly getting under way and plans are practically perfected in one school section, and are being established in others very rapidly. There are a few school districts where a too limited number of men have applied to do Mantoux tests to satisfy the ideal set-up. We may have to contact all members of the society in this section by postcard. All the organizations interested are anxious to get as much of this work done by the end of this school year as possible. The money which has been appropriated by the Board of Freeholders must be used, if at all, during 1937.

Dr. Carpenter has worked arduously on the Venereal Disease Control problem. I would like to quote part of his report in connection with the statement contained in the agreement between the State Medical Society, State Board of Health, and the State Social Security Board.

"Rotating services at Venereal Disease Clinics with a place for every doctor who has an interest in venereal disease. The Board of Health should encourage the private physician to attend Venereal Disease Clinics, so that he may observe and discuss diagnosis and methods of treatment. The private physician carries out treatment of the patient better than clinics if he has proper instruction, free diagnostic service, free drugs, and free consultation."

The State Board of Health is about to make it possible for physicians to obtain free drugs to treat venereal disease cases in their offices, and to make it possible by changing the statutes to report venereal disease by initial, number, or address, instead of by name as is now required by the law. It is very necessary that the physicians' confidential information be preserved.

Under the Social Security Act, certain funds are being used in this State to perfect the establishment of Venereal Disease Clinics, paying physicians to do the work. It is recommended that these services be rotating. It is required that applications for appointments in these clincs be made officially to the County Medical Society, who will send the approved list of members to the State Public Health Committee whence the appointments are made by the State Board of Health in connection with the local health authorities; the doctors to receive $5 for each visit to the clinic, or more if the service warrants it.

Just as there have been misunderstandings in other directions, there have been misunderstandings here. In order that the State Board of Health approve the expenditures of the Social Security funds, the applications must be made through the County Medical Society, or its empowered officers. This will assure that the men who draw salaries in these offices will be men in whom the County Society has confidence.

THE WOMAN'S AUXILIARY

THE WOMAN'S AUXILIARY

The Woman's Auxiliary to The Medical Society of New Jersey held its annual meeting coincidently with that of the medical organization. The official register of the Auxiliary showed that 226 members were present.

All the features of the program were carried out promptly and successfully. There was a pleasant rolling chair ride on the Boardwalk on Tuesday afternoon, and a Fashion Show on Wednesday afternoon, and a luncheon on Thursday noon.

The Executive Board met on Tuesday afternoon, and a general business session was held on Wednesday afternoon.

On Wednesday evening the Auxiliary sponsored the Banquet and Ball in honor of Dr. Spencer T. Snedecor, President of The Medical Society of New Jersey.

The Art, Hobby, and Historical Exhibit of the Auxiliary was open throughout the entire time of the sessions, and is described in the preliminary report of the Chairman, Mrs. Adele M. Beir, of Atlantic City.

On Thursday noon a luncheon was held, at which Mrs. Rogers, President, introduced the officers in turn. President Herrman of the State Society read the following original verses on the important rôle of the Doctor's Wife:

THE DOCTOR'S WIFE

When you come home as daylight dawns,
Who turns in bed, and only yawns?
The Doctor's Wife.

In broken bone or typhoid fever,
Who thinks you're tops like John B. Deaver?
The Doctor's Wife.

When accounts run low and it's your crisis,
Who lets you down by easy lysis?
The Doctor's Wife.

When you're so tired you could die,
Who lifts the 'phone and tells a lie?
The Doctor's Wife.

'Less some one lies and screams with pain,
Then sends you out in snow or rain?
The Doctor's Wife.

If I am by you understood
Who takes care of the neighborhood?
The Doctor's Wife.

THE EXHIBIT OF THE WOMAN'S AUXILIARY

The Art, Hobby, and Medical History Committee of the Woman's Auxiliary to The Medical Society of New Jersey submits the following preliminary report:

During the last few years the exhibitions of this committee, at our annual conventions, have become real attractions to many members of both the State Medical Society and our Auxiliary.

From its start as a social meeting place where were shown a few articles of handicraft and art made or collected by members, these annual exhibitions have expanded into showings of real art, valuable and unique curiosities, comprehensive and costly collections of hobbies and art, and lastly, the initial showing at the 1936 convention of articles and records of medical historical interest, especially that of New Jersey. The number of entrants, entries, and visitors has steadily increased until last year, when our rooms were visited by over 1000 guests.

Formerly our visitors were mainly those women who came not only to see the exhibits, but to rest, to meet friends, and to take tea. Last year, besides these attractions, we had many objects and collections of interest to men, and were especially favored by a most interesting and well-attended talk by Dr. Frank Overton on New Jersey Medical History, which, in a manner, dedicated the undertaking of Medical History recording by this committee. As a result, attendance figures greatly increased and almost 50 per cent of these visitors were doctors. This was especially gratifying to me, in view of the many other attractions of the meeting, as I felt that interest in our exhibitions might induce many to come, and so increase the convention registration in years to come.

Because the collection and showing of articles bearing on Medical History, especially that of New Jersey, aroused so much interest among officials of the State Medical Society and our Auxiliary, I felt that the rich traditions and history of medicine of New Jersey, especially that of its State Medical Society, the pioneer in our nation, deserved to be recorded and preserved for us as well as for future generations. For this purpose, in addition to the collection

and exhibition of this material, I planned the compilation of Archives of the Medical History of New Jersey that would include the History of the State Medical Society together with a list of its Past Presidents, their biographies and photos; also the same for each County Medical Society; biographies and photos of doctors who had practiced fifty or more years; genealogies of medical families with a doctor in three or more generations; biographies and photos of doctors of outstanding importance in medical, governmental or sociological affairs; and lastly, descriptions or copies of medical curiosities, diplomas, minute books, papers, records, etc. As this work has been made a major objective of the Auxiliary, this outline is repeated from my preliminary report of last year to secure better and wider understanding of our purposes and methods of procedure by members of both the State Medical Society and our Auxiliary.

The machinery for collecting and recording this material by our committee is the State Medical Society, the Medical History Committees of County Auxiliaries, and the Historians of County Medical Societies. This material will be prepared for exhibition at our annual conventions, and copies or records made for the Archives. Such articles as are loaned for exhibition by individuals or societies will be returned after the convention; articles made or acquired by County Medical History Committees, by this committee, or by the State Medical Society, will be placed by the State Medical Society in such a place as it deems safe and convenient for its officers and members, whether in Trenton or such a place as the Academy of Medicine of Northern New Jersey, or a possible Academy of Medicine of Southern New Jersey. All material will be recorded. The form the Archives will take has not been decided upon, but it seems to me that separate loose-leaf books, one for each classification, together with an index system, would make these records more convenient for showing at the annual conventions.

My suggestion that the name of this committee be changed to that of "Art, Hobby and Medical History Committee" was endorsed by Mrs. Rogers and the Executive Committee and approved by the State Medical Society and is now in effect.

Last Fall I wrote each County Auxiliary President asking that she appoint a Chairman and Committee on Medical History to work up the medical history of that county. To each chairman I wrote detailed information on the plan for forming Archives, and instructions on how to acquire and work up local medical history data, and especially to consult with the Historian of the local medical society. Early this year I sent them further instructions. About a month ago I wrote them in respect to sending in their entires, and preparing their county exhibit material for exhibition and also for recording it.

If incoming Presidents of County Auxiliaries will send me, as soon as possible, the names of their Chairmen of their Medical History Committees, it will help this work go forward with little interruption.

Early this year letters requesting entries for our annual exhibition were sent, with entry blanks, to all County Medical Societies, Auxiliaries, former exhibitors and prospects. As you may imagine, there has been *some* correspondence.

Because of its greater size and splendid natural and artificial lighting, I have selected the Benjamin West Room for our exhibition, which is on the same floor as that where the meetings of the Auxiliary take place.

On account of the anticipated further increase in the number of exhibits, especially those of medical history, the greater attendance and the work of compiling Archives, I estimated that $150 would be needed this year to provide more showcases, special lighting fixtures for paintings, increased costs for tea service, and the greater expense incident to many form letters and a vastly increased correspondence. Mrs. Rogers graciously approved my request, for she has heartily seconded my efforts and coöperated in every way, and this amount was appropriated for this committee by the State Medical Society.

There are seven group exhibits by Medical History Committees; 1718 Art and Hobby entries have been received from forty-one entrants; 255 Medical History entries have been received from thirty-five individual entrants. Complete figures will be given in my final report.

Of these entries, many are very wonderful, yet I cannot refrain from enthusiastically recommending that of Dr. Edward J. Ill, which occupies three showcases, and consists of ancient medical books written by men famous in medical history, very old medical wood cuts, ledgers, etc., of great value, rarity, and interest, together with a collection of medical commemorative medals. This is only one of the many collections and objects that I believe will merit your interest and many visits to our room.

Mrs. Ily R. Beir, *Chairman.*

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Magnesium (Mg)	5.8	0.34
Sodium (Na)	5.6	0.33
Potassium (K)	Trace	Trace
Bicarbonic Acid, Radical (HCO_3)	43.1	2.52
Carbonic Acid Free (CO_2)	7.0	0.41
Sulphuric Acid, Radical (SO_4)	27.1	1.58
Nitric Acid Radical (NO_3)	1.8	0.11
Chlorine	4.2	0.25
Phosphorus	Trace	Trace
TOTALS	128.9	7.54
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Place	Name and Address	Telephone
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MONTCLAIR	Wm. J. McNulty, So. Fullerton Ave. & The Crescent	MOntclair 2-2014
MONTCLAIR	Upper Montclair Pharmacy, 629 Valley Rd.	MOntclair 2-1665
EAST ORANGE	Clinton Pharmacy, 481 Central Ave.	ORange 5-6868
EAST ORANGE	The Professional Laboratory, 144 S. Harrison St.	ORange 5-7430
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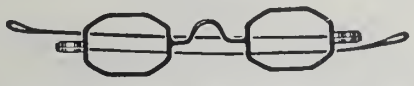
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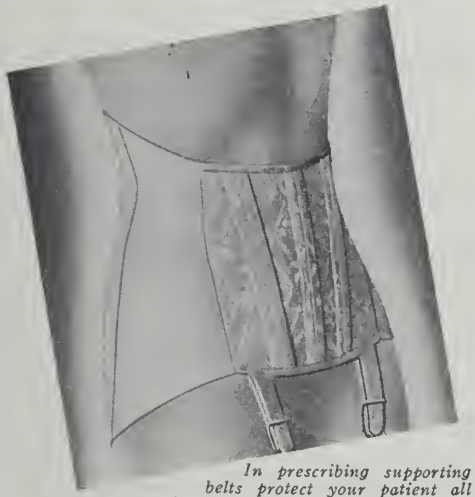
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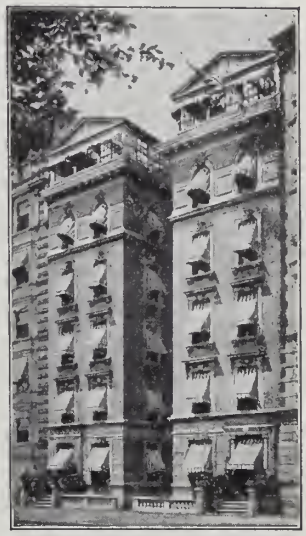
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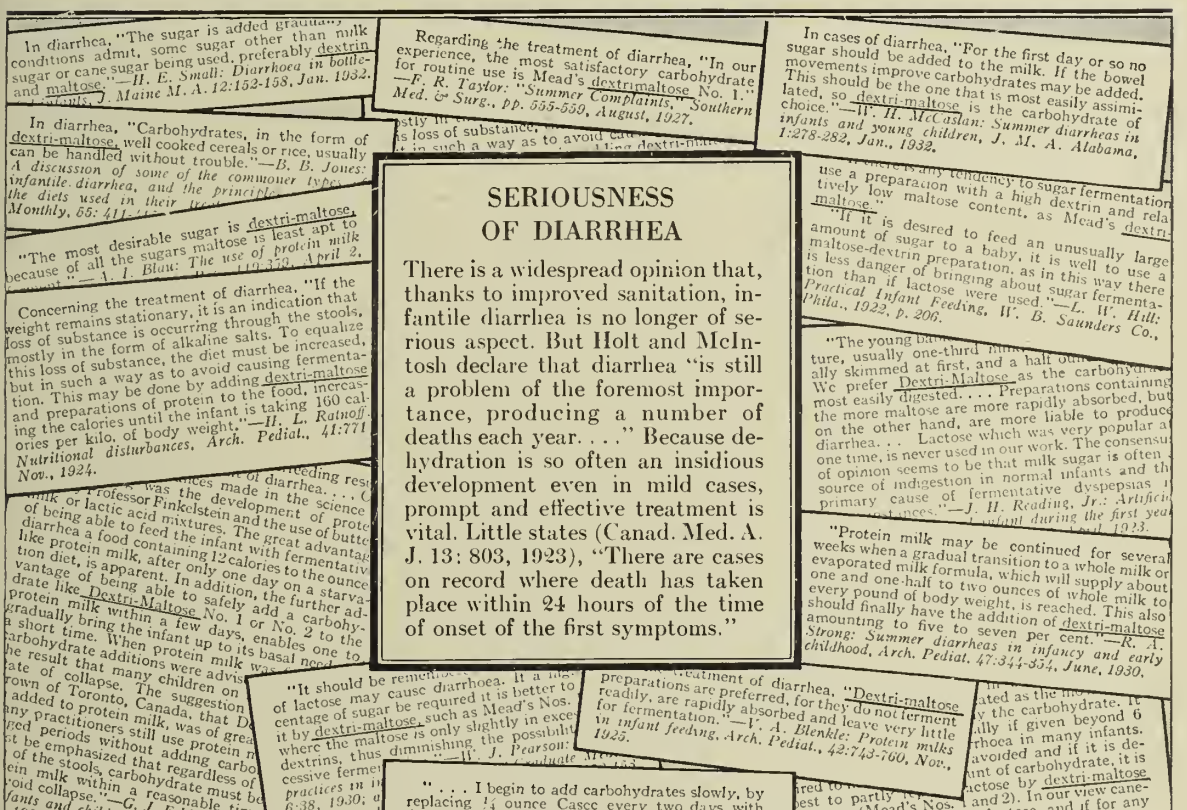
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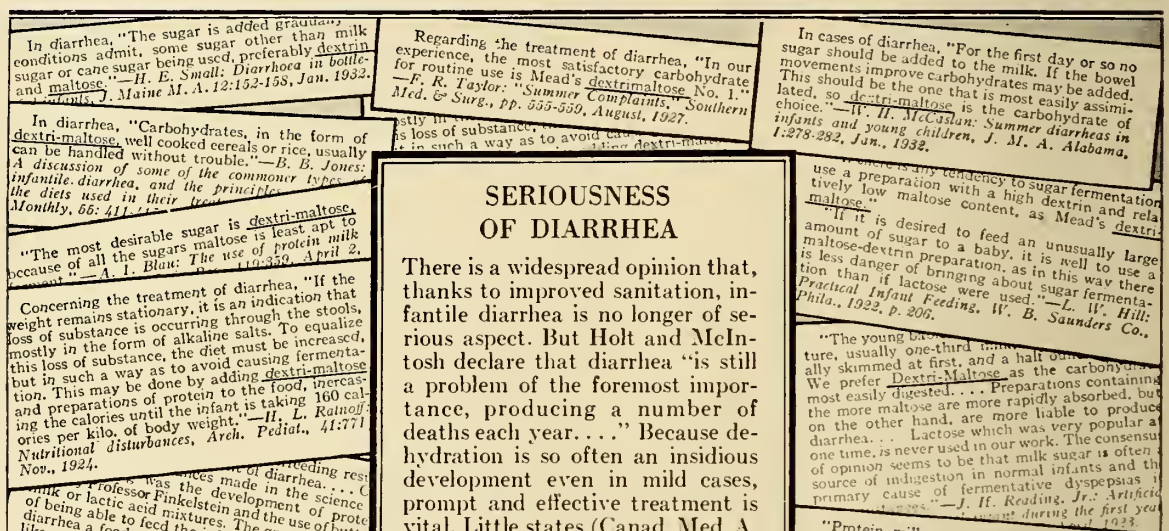
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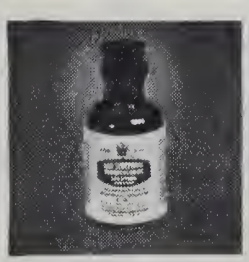
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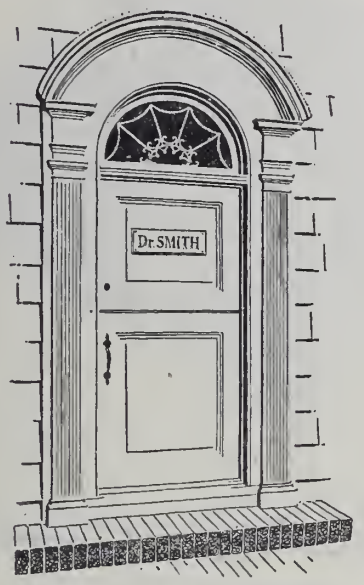
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(1) 1934-35. Am. Pub. Health Assn. Year Book. Page 70

(2) The Vitamin B Requirements of Man. G. R. Cowgill Yale University Press. New Haven. 1935

(3) 1936. Nutr. Abst. and Rev. 5, 855

(4) a. 1936. J. Am. Med. Assn 106, 261
b. 1935. Ibid. 105, 1580

(5) a. 1932. Ind. Eng. Chem. 24, 457
b. 1932. J. Nutrition 5, 307
c. 1934. Ibid. 8, 449
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(6) 1934. U.S. Pub. Health Rpts. 49, 754

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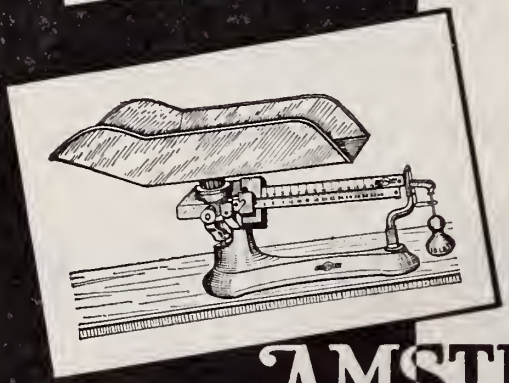
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EDITORIALS

After the Annual Meeting, What?

Historically and practically, The Medical Society of New Jersey is the parent organization from which the county societies derive their existence, their plans of activities, and their morale.

On the other hand, the State Society leaders consist of physicians who have been trained in the school of the county society. They have served as private practitioners in the ranks of members, and as officers in the squads and companies of their county societies, and thereby have gained the experience which qualifies them to develop state-wide standards and methods of practice for all the physicians of the State.

The administrative year of organized medicine in New Jersey begins at the close of the Annual Meeting when the newly elected officers, numbering less than a dozen, assume office. Their first duty is to choose nearly two hundred of their fellow members to serve as chairmen and personnel of the several committees. The twenty-one schools of the county societies have trained a sufficient number of well-qualified members to fill all the State offices twice over, but it is extremely wise to recognize every county society in the choice of appointees. A working chart has been made in order that the new appointees may be distributed equitably throughout the State.

Several new committees which were formed last year have been made official, and some that were doing overlapping duties have been merged into single units which were recognized in a revision of the Constitution and By-Laws, and approved by the House of Delegates.

The next action will be a formal meeting of each committee, in order to outline its objectives and its plan of action during the year.

Special measures will be taken to recognize every county society as an essential unit of the State Society. To this end every county society is urged to carry out the suggestion that was made last year to make its arrangement of committees conform to that of the State Society, so that each one may take full advantage of the plan of action adopted by a similar committee of the State Society.

The prospects are bright that the physicians of New Jersey will assert their unified leadership more effectively than ever before.

Organized Health Services

Organization is an essential factor in every field of human relations, especially in the delivery of medical services. The fundamental principle in the practice of medicine is the delivery of medical service by an individual physician to an individual patient. The ideal state of medical practice is that in which two conditions are fulfilled:

1. The individual doctor shall have the *skill* and the *will* to deliver the scientific service which is best for the individual.

2. The individual patient shall be *willing* and *able* to carry out the advice of his physician.

DIAGNOSIS

Great Foundations have made extensive studies in order to determine the extent to which this ideal service has been delivered; and their conclusions are that less than half of the persons in the United States are receiving the ideal service which medical science can offer to the people. The major reason that the Foundations assign for this inefficiency is that the medical profession is backward in supplying the needed services. On the other hand, the major reason assigned by practicing physicians for the failure of the people to utilize their services is that a large proportion of the people are either unable, or unwilling, to apply the services which are offered to them by physicians.

TREATMENT

The treatment proposed by the promotors of the studies is that physicians be hired at public expense to give the needed services,—in other words, *State Medicine*. This plan presupposes that the people will accept and carry out the advice of the appointed doctors to the fullest degree. To this end a great number and variety of lay organizations have been formed for the purpose of influencing the people to make wise use of facilities which will be offered them at public expense. These organizations adopt the advertising methods of great business corporations in selling automobiles, ice boxes and radio sets. Yet the people continue to spend as much on quack medicines and beautifiers and tonics as they do on legitimate medical services.

The treatment proposed by The Medical Society of New Jersey is that physicians, through their organizations, shall assume the leadership in all measures of public health and related services. If, for example, a clinic is proposed, the representatives of the county society shall determine its scope and its method of operation; or if a patient needs relief, the physician shall advise the kind and amount, and who shall furnish it. The Medical Society shall be the adviser of the lay organization, just as the family doctor is the adviser of the family of the sick person, as well as of the patient. The Medical Societies have made an excellent beginning of this service through its advisory committees on crippled children, maternal welfare, child health, and venereal disease, and by the adoption of measures that are described in the Handbook of Preventive Procedures for Family Doctors.

MEDICAL CONTACTS WITH LAY HEALTH ORGANIZATIONS

The most evident measure that the medical societies can take to regain the leadership which rightfully belongs to the Family Doctor is that they shall form intimate contacts with the lay organizations,—attend their meetings, take part in their discussions, and report their activities in these lines in the Journal of the Medical Society and in the daily press. Already the lay organizations are capitalizing as news the fact that the medical profession is recognizing the value of their work. In a few short years, the lay organizations will admit the leadership of the medical profession, and will earnestly seek the advice of the medical societies *before* undertaking a new project. When they do this, the practice of public health measures will be carried out with efficiency, and with the support of the people.

The Practice of Medicine by County Societies

It is a fundamental law of the land that a corporation cannot practice medicine; and that the actual delivery of a diagnostic or therapeutic service is the responsibility of an *individual* doctor. For example, the operating surgeon is responsible for an operation done on ward patients who seek relief in a hospital.

Yet in a very real sense a medical society has an important part in the practice of medicine by establishing the standards of the services which a private practitioner renders, and the methods by which he secures the coöperation of accessory agencies of nursing, relief, and welfare.

The law states that the services rendered by a private practitioner shall be according to the methods of practice that are available in a community. For example, the law does not compel a family doctor in a small village to conform to the surgical standards which are prevalent in a large city in which complete hospital and ambulance services are at his call.

The laws of many States are giving increasing recognition to the medical societies of the States and the counties, and are authorizing the societies to adopt standards and methods of procedure in public health activities. Although a medical society cannot legally conduct a hospital or give a treatment, yet it can use its influence in the establishment of a hospital, or other organized means of giving medical relief. In fact, the law often directs that a medical society shall designate a certain number of its members as its representatives on the board of managers of an institution.

It is therefore entirely legal that a medical society shall perform certain functions which are essential in the practice of medicine. For example, it is legal that a member of the attending staff of a hospital shall be a member of a county medical society. This excellent requirement is in force in many hospitals of New Jersey.

The field of the participation of medical societies in the practice of medicine is constantly being enlarged; and certain phases of this function are recognized as both necessary and legal.

Dates of Taking Office in County Societies

Owing to a peculiarity in the methods of work and organization of physicians in New Jersey, it is important that the terms of officers and committeemen of the county societies shall begin and end at the same time as those of the State Society. The administrative leaders of both the State Society and the county societies hold office for one year; and during that time they do not merely float passively along with the tide of public opinion, but they produce their own internal power by which they actively drive their way against opposing currents toward definite objectives.

The official year's work of a medical society naturally divides itself into three stages:

1. That of planning the activities for the year, choosing the committees, and initiating them into their work.

2. That of carrying out the details of the plans as the chosen leaders, making personal contacts with their fellow members, and with representatives of other organizations engaged in projects that are accessory to medicine.

3. Closing the projects of the year, and preparing reports which evaluate the results of work accomplished during the year, outline the methods followed, and suggest the best lines for the next year's work.

About a year is required to initiate a project and carry it out with a reasonable degree of success;—and a year of active service is about all the time that the average volunteer worker can be expected to give to a project that is outside of his routine of thought and action. A year is therefore the natural unit of time in medical society work.

The leaders of the State Society are recruited from those physicians who have been trained in the school of the county society, and have made wide contacts with not only sick

persons, but also with the patients' families, their neighbors, and their fellow citizens in the county, state, and the nation.

The final act in any plan of the State Society is the delivery of service or advice by local physicians acting according to standards set by their county societies. The officers of the State Society retain their leadership because they not only note the medical needs of individual patients, but also consider the concrete methods by which all groups of citizens may be induced to coöperate in rendering a unified service to the needy.

The county medical society is a replica of the State Society; and on the other hand, the State Society is a close federation of the county societies. The interest of both are identical, yet up to three years ago it was the custom of the majority of the county societies to change their officers in the middle of the terms of the State officers, thereby involving the new officers in responsibilities for which they were unprepared and in whose planning they had not participated.

Efficiency demands that the terms of the officers and committees of the county societies shall begin and end at the same time as those of the State Society. The encouraging amount of progress that has been made in securing a conformity of dates of service of county societies with that of the State organization is shown in the table on page 400.

Over four-fifths of the county societies, including all of the larger ones, are now acting under a uniform system of coinciding terms of office.

Historical Features of The Journal

Each issue of The Journal features the dominant activities of The Medical Society of New Jersey and those of the county societies. This issue calls attention to some historical features which have been essential in the development of the present high state of organized medicine. The reference in the May Journal, page 342, to the presence of Dr. Joseph B. Harrison, of Westfield, attending his sixty-first consecutive Annual Meeting led to the discovery of the record of Dr. Obadiah H. Sproul, of Flemington, in attending fifty-three consecutive Annual Meetings. Research disclosed his life-long record as Secretary of the Hunterdon County Medical Society, and his term as President of The Medical Society of New Jersey, followed by service as a Trustee during the rest of his life. His was a record of service rendered so quietly and yet efficiently that the results of the service endured, while his own unassuming part was almost forgotten.

This is the tenth anniversary of the setting of the tablet placed in the Presbyterian Church of New Brunswick to the memory of Dr. David C. English, whose services to his church were as conspicuous and efficient as those which he rendered as President of The Medical Society of New Jersey and as Editor of the Journal during eighteen years of the formative period of the State Society as it exists today. Extracts from the dedicatory address by Dr. Wells P. Eagleton constitute one of the best statements of the objects of The Medical Society of New Jersey that have ever been written. These facts justify a reference to the life and ancestry of Dr. English, who was of the third generation of a line of medical men of New Jersey.

Reading the certificate that Dr. Elias J. Marsh had passed the examination held by the censors of Middlesex County in 1827 recalled the services of Dr. Marsh, who became President of the State Society in 1850, and to the services of his son, Elias J. Second, also President, and finally to Elias J. Marsh, Third, now Treasurer of the State Society.

It is fitting that the outstanding services of all these medical men should be called to the attention of the members today for their encouragement and inspiration.

The Standards of The Medical Society of New Jersey

The high standards and ideals of The Medical Society of New Jersey were exemplified by Dr. David C. English to a greater degree than by any other member; and his eighteen years as Editor of The Journal gave him a unique position of influence which will never end. These ideals were well expressed in the following quotations from the dedicatory address by Dr. Wells P. Eagleton at the unveiling of a tablet to Dr. English in the Presbyterian Church of New Brunswick on May 15, 1927 (Jour., July 1927, p. 443):

"During the whole of his editorship he regarded The Journal of The Medical Society of New Jersey as a family affair—the voice of the family. It existed to preserve the clan, to hold it together, to shield it, to interpret it to itself, to honor it. During the many years of editorship no word or insinuation, no mean or petty jibe against a member of the medical profession of New Jersey darkened its records or marred the justice due its fellows.

"He had faith in New Jersey doctors because they were doctors, and this in spite of trying moments and many petty antagonisms, for Dr. English was not a meek man; he was a haughty and self-assertive man, and he practiced a living, working, fighting faith with tireless energy to the end. He believed that it was not only beneath the ethics, but the dignity, of the profession to resort to recognized political expedients; and the severest condemnation I ever heard him voice was against a physician for playing 'practical politics'—'log-rolling', as he contemptuously called it.

"Tolerant of creeds, he vigorously opposed the slightest infringements of divine injunction. I well remember a letter virorously protesting against the holding of committee meetings on Sunday. To him, 'Six days shalt thou labor, and do all thy work, but the seventh day is the Sabbath of the Lord thy God', was to be obeyed, not only in spirit but to the letter.

"In his thought there was no conflict between religion and science. He welcomed all advances with enthusiasm, as a tribute to man's genius and a revelation of the Master's greatness".

These ideals still actuate the members of The Medical Society of New Jersey, with the possible exception of those regarding committee meetings. But Dr. English belonged to the church militant, and those physicians who attend the meetings of the Welfare Committee on Sunday afternoons might well consider that the reports were panel discussions like those conducted in many churches on the duties of man to his fellows, whose essence is "Thou shall love thy neighbor as thyself".

Former Medical Leaders

The Medical Society of New Jersey as it exists today is the evolution of the lives of those devoted members who through one hundred and seventy-one years have developed its standards and methods of service. In this issue there appears accounts of seven faithful leaders and servants, belonging to three families.

Dr. Obadiah H. Sproul, of Flemington, was elected President of The Medical Society of New Jersey in 1894, and then served as Trustee until his death in 1925, achieving the distinction of fifty-three years as Secretary of the Hunterdon Medical Society, during which time he attended every meeting of The Medical Society of New Jersey. This record has been surpassed by only one member,—Dr. Joseph B. Harrison, of Westfield, who attended his sixty-first consecutive Annual Meeting this year, and whose portrait was printed on page 342 of the May Journal.

The inspiration of The Journal was Dr. David C. English, Second, who was President in 1894-5, and then served as Editor until his death on September 19th, 1924. His uncle, his father, and his grandfather were prominent physicians before him.

Three members of the Marsh family bear-

ing the name of Elias Joseph have furnished two Presidents of The Medical Society of New Jersey, and its present Treasurer.

Accounts of the lives of these seven medical leaders are published in this Journal, beginning on page 396.

Such men as these were pioneers in medical organization, and builded far better than they know. The present generation of physicians are the inheritors of the ideals and standards which they originated out of their own high character and conscientious observation.

It is planned that the lives of other leaders in The Medical Society of New Jersey shall be published as the information is obtained and the occasion arises. Here is an opportunity for the county societies to search their records and to perpetuate the memories of those who have helped to raise the Medical Society to its present high standard.

Records of Mass Examinations

A major reason that family doctors dislike public clinics is that they must make a record of the diagnosis, treatment, and progress of each patient. It is difficult to combine salesmanship with bookkeeping. The promotors of clinics think of the patients as a group,—so many examined, so many found defective, and so many placed under treatment. They provide an abundant number of clerks to keep complete records of all the cases, to study and analyze them, and thereby to enlist popular interest and support.

A county medical society that desires to participate in mass examinations, such as tuberculosis testing, finds difficulty in competing with other groups to whom the physicians' services are made available, because the lay groups provide clerks to keep complete records of not only the patients, but also of the amount of service rendered by every worker in the group.

Making a record often takes more time than the delivery of a service. A doctor is a doctor because he prefers to be a doctor rather than a recording clerk.

The solution of the problem of clinical records is that the doctors shall require the promotors of a clinic to provide competent recording clerks.

L. A. W.

A Medical Supplement in a County Newspaper

The best idea is the one which you originate yourself.

The next best is the one which you glean from someone else.

We have long cherished the idea that it would be a good thing to make a survey of every county medical society in New Jersey.

An improvement on that idea,—or rather an application of it,—is stated in the May Journal of the Michigian State Medical Society, page 336, which says that the Detroit Free Press will publish a medical supplement some time in May, under the auspices of the Wayne County Medical Society. Its object is to tell the people that the county has an active county medical society, and inform them of the public health projects which it is carrying on.

We have frequently had occasion to present our editorial card to business men; and the usual reply is, "What is the county medical society?" and "What does it do?"

A newspaper supplement conducted by a county medical society will answer these two questions in an effective way.

We know two or three counties in New Jersey in which conditions are already ripe for the undertaking.

Is this idea worth trying?

ORIGINAL ARTICLES

SOCIETY AND ORGANIZED MEDICINE

By Charles Gordon Heyd, M.D., New York, N. Y.
President of the American Medical Association

Abstract of an address delivered before the General Session of The Medical Society of New Jersey at its 171st Annual Meeting, held in Atlantic City, April 27, 1937.

Medical service is a fundamental need of every individual; and to provide it is the object of medical practice.

In general, modern medical service today is effective and efficient, although not always adequate or available.

The payment of physicians for medical services is not the large item in the so-called cost of medical care, as less than 50 per cent of hospital patients pay any fee to their doctor.

In the cost of medical care it is improbable that the item of professional service can be lessened.

The doctor is a citizen and must discharge all his obligations of citizenship.

The doctor cannot be expected to work under a system that is ethically wrong, and economically unsound. He must be paid for his services in order to function as a useful member of society.

The principles of mass production in modern industry cannot be applied to the practice of medicine. *Curative* medicine is not the assembling of parts. It is a study of a disease in an individual with his own peculiar personality and hereditary background, under varying conditions of environment and financial competency.

Preventive medicine to a certain extent is capable of responding to the application of mass production. Patients' secretions may be analyzed, temperatures taken, physical examinations made, complete x-ray surveys carried out. All the data can be put on cards so that you have a complete record of the individual's physical state. But, you cannot cure that patient or tell him how to live by handing him a slip of paper, advising him to read it, and to carry out his own treatment, his own preventive medicine. At some place in the final analysis there must be a personal touch and a psychological evaluation of the patient in regard to the advice that is given to him.

INDIVIDUAL AND COLLECTIVE PROBLEMS

While the delivery of medical services must be made by an individual physician to an individual patient; yet there are certain problems with relation of the physician to society that must be handled in the county unit—contacts with local boards of health, etc. There are certain problems that must be handled by the State—such as Workmen's Compensation. There are certain problems that must be reserved to the national body—the American Medical Association.

From time to time we hear a great deal derogatory to medical ethics and within recent times the code of medical ethics has been declared "bunk". Fate, political chance and accident elevate men of varying ability to high places whereby they speak with authority, but it does not always follow that the mere elevation of a particular man to a place of political prominence at the same time raises his intelligence or increases his capacity for clear thinking.

An inherent part of the free soul of medical organization is the code of ethics. The code of ethics was devised, given form and longevity, and endowed with a soul for the primary purpose of benefit to the community. It defines the duties of a physician to his patients; and the fundamental purpose is to protect the patient and to assure to him correct treatment, right conduct, and personal responsibility upon the part of the physician.

The most potential agent for our splendid health record has been the disinterested, unselfish public education that has been carried

on by the county and state medical societies, and the American Medical Association. A large portion of the funds of these various units of organized medicine has been expended in informing the public of desirable measures for personal and public health.

So far as organized medicine assuming, as is alleged, a vested interest in sickness, it has through the years brought about a constantly diminishing rate of illness, so that it is practically the only big organized function of society that is improving conditions and at the same time lessening its field of remuneration.

EFFICIENCY OF ORGANIZED MEDICINE

Let us consider the answers to some queries which are asked regarding the efficiency of the present system of medical practice.

1. Is medical practice efficient? The answer is found in the reduction of death rates to a point below that of European countries which have adopted governmental control of medical practice.

2. Has the practice of medicine kept pace with scientific progress in other lines?

A profession that has produced insulin, liver therapy, vitamin therapy, orthopedic and cancer and restorative surgery, and advanced in x-ray diagnosis, and x-ray and radium therapy, has certainly been so productive in discovery as to be well in advance of any of the divisions of physical science.

3. Has the distribution of medical service been effective? It must be admitted that in our country there are some geographical inadequacies of medical service, but I think it may be stated safely that the deficiencies of distribution of medical services are not at all comparable with the illiteracy that exists in some of the backward areas, nor with the inadequacy of nourishment, living conditions, and housing. In addition, it might quite well be challenged whether the distribution of medical services can be adequate for certain areas until the basic defects of education have been overcome, until more roads are built, the sparsity of population overcome, and the needs of some remote groups of citizens aided by effective contacts with scientific medicine.

The outstanding defect of both the foreign systems is that they divide the practice of medicine into a class practice and the measure of effectiveness of the medical service is dependent upon the economic status of the patient. There is thus created a superior type of medical service for the well-to-do, and a substandard type of medical practice for those in the lower economic brackets. The practice of medicine in the lower economic group becomes largely a prescription practice—a brief visit to the doctor, a scant short history, and a prescription or the dispensing of a bottle of medicine. One of the most tremendous steps in the practice of medicine in America is that it has become a diagnostic practice, a practice based upon a complete physical examination, scientific laboratory determinations, and the direct opposite of a prescription form of medical practice.

4. Has organized medicine improved medical standards and medical education? Improvements in medical education and the measures for protecting the community from inferior practitioners have arisen from within organized medicine.

The record shows that the organized profession through its medical societies, and under the leadership of the American Medical Association, has fulfilled its obligation to society; to go forward in effectiveness and in scientific progress.

INSURANCE

The insurance principle as applied to human sickness is acceptable only in buying hospital lodging, accommodations, food, and general nursing care. The insurance principle applied to the employment of professional services will fail because there are inherent in it defects that depend upon the variability of human beings. Medical service is not a mechanical gadget that can be fabricated. Medical service is the relationship of a doctor and a patient; both are animated human individuals; both are

equipped with their own personal psychology; and the character of the medical service rendered is the application of scientific knowledge plus certain intangibles to the patient's medical problem plus the ability and psychology and sympathetic contact of the doctor. This is not an insurance proposition that can be calculated or estimated upon an actuarial basis.

A constantly recurring enigma seems to be—why some altruistically-minded individuals in high office apparently wish to foist upon an inadequately informal American people a system of medical practice of demonstrably inferior quality and at a constantly increasing cost, with a huge extension of administrative expense—all this to be paid for by invisible or indirect taxation. Why substitute this for a tried and functionating, adequate, good medical service, distributed at the present time at a surprisingly low cost and without bureaucratic or political administration. I know of no way to judge the future except by the experience of the past. Why should we discard all of our experience and enter upon a path of trial and error and which eventually leads to a poorhouse medical practice.

WHAT CAN THE PRIVATE PHYSICIAN DO TO AID IN THE CONTROL OF SYPHILIS?

By Thomas Parran, M.D., Washington, D. C.
Surgeon General, United States Public Health Service

Read before the General Public Health Section at the Annual Meeting of The Medical Society of New Jersey, April 27, 1937.

The private physician is the keystone of the arch in any program evolved for the control of syphilis in this country. There has been up to this point a very generous outpouring of medical coöperation, both professional and personal, for the objectives of syphilis control. What the individual physician can do, to my mind, would be summarized as follows:

CASE-FINDING

1. He should set his "index of suspicion" for syphilis somewhat higher, using Stokes' well-known phrase. Even where there are no obvious clinical symptoms to indicate it, he needs to keep looking for syphilis.

For example, there is the well-known survey of obstetrical clinics in Philadelphia hospitals, made by Haven Emerson, of Columbia University. One group of these hospitals made a test only when the history or examination led to the suspicion of syphilis. As a result, twelve cases of syphilis were discovered among 19,411 patients.

A second group of hospitals serving the same type of clientele made routine Wassermanns on all patients and discovered 112 cases among 2559 patients.

The Danes set a good example for us in this respect. In spite of the fact that in Denmark the syphilis rate dropped from 4307 cases in 1919, to 648 cases in 1933, the Danes are not over-optimistic. They continue to look for it. Practically all hospitals use the Wassermann test routinely as part of the entrance examination of every patient for any cause. In Denmark about 110,000 blood tests are performed each year to find an average of some 600 cases, or a ratio of about thirty tests per 100,000 population. On the same basis, one should expect 4,000,000 tests per year in the United States, rather than 2,063,837 Wassermann or similar tests reported by State departments of Health in 1936. Moreover, there is less need of the Wassermann drag-net there than here, because patients are much less deterred by embarrassment, and not at all by cost or the lack

of convenient facilities, from presenting themselves for treatment.

A COMMUNITY PROBLEM

2. Remember that syphilis is a community problem as well as a personal problem. It is highly communicable. Its results, if untreated or poorly treated, are dangerous and costly, both to the individual and to the community. Any disease which affects so many people and the effects of which, mishandled, constitute so large a part of our public tax burden, must inevitably assume a public interest.

TREATMENT TO PROTECT OTHERS

3. Remember that the greatest protection to the patient is synonymous with the greatest protection to the community. Protection to the patient means keeping him under continuous treatment, not only until he has passed the infectious stage, but until he is cured. The cooperative patient need suffer far less intrusion into his privacy than if he had measles or scarlet fever. Yet in this country, according to reports from hospitals, clinics, and physicians, 60 to 80 per cent of our syphilitic patients discontinue treatment while still in the infectious stage.

To quote the Danes again, in a study of 5200 cases of venereal disease, 80 per cent completed their treatment without interruption; 20 per cent lapsed and received a warning; and only ninety-one of these, or less than 1.7 per cent, were not located and returned to treatment.

THE WASSERMANN NEGATIVE PATIENT

4. Treat the patient and not the Wassermann. This means darkfield diagnosis in the sero-negative stage whenever and wherever possible; also, skilled adaptation of the best known methods in modern syphilology, both for the patient who early becomes Wassermann negative, or for the patient who continues for a long period to be Wassermann-fast.

Incidentally, it means that every physician treating syphilis should keep continuously in touch with what the research and practice of the specialist has demonstrated for us.

THE DOCTOR AND THE HEALTH OFFICER

5. Be willing to do teamwork with the health officer. From the practical point of view, this insures a public health program in which clinical medicine carries a full share of responsibility, and gains a full share of credit. In many of our communities it is through the public-spirited interest of the private physician that health officers have been kept on their toes to coöperate with physicians in the finding of cases and keeping them under treatment, and the tracing down of sources of infection and rendering them harmless.

THE COUNTY MEDICAL SOCIETY

6. Stimulate the local medical society to a sense of direct responsibility in each community for:

a. The definition of the syphilis problem. How many cases have you? This implies a review of the completeness of your reporting in each community, and the laboratory standards upon which such reports are based.

How adequate are the facilities for treatment of your cases?

Are your clinics for the indigent arranged in convenient places?

Are they operated at convenient hours?

Are the patients treated with decency and consideration?

Are they educated as to the seriousness of their disease, the importance of keeping under continuous treatment, and the urgent necessity for the examination of contacts?

Is there provision in your community plan for the borderline patient who is willing and able to pay a little, but for whom eighteen months of continuous treatment in the specialist's office is impossible?

b. Standards of clinical and laboratory service:

You know far better than I—though a flood of material pours into my office about it—that there are those who still give a few doses of arsphenamine and send the patient home as cured when his surface symptoms clear up;

that there are those who take a Wassermann on the patient who comes in fearful that he has syphilis, and if it comes back negative because the patient is in the sero-negative stage, they tell him to go home and forget about it. You know that there are clinics undermanned and overworked—perhaps not in this State but certainly in many others—where the standards of service are lamentable.

You know, too, that when the corner drug store advises self-treatment and the local newspaper advertises patent nostrums that every doctor's syphilis problem is complicated thereby.

The management of these things is best accomplished through the personalized interest of each local medical society. Each doctor interested in syphilis has a responsibility for the spirit of his own medical society toward the community problem.

In conclusion, let me remind you of what the late, great Dr. Osler said as early as 1909:

> "Venereal diseases should be put in the same category as other acute infections of public danger, and every case should be known, registered, and supervised. Chimerical, futile, even nearer impossible! Yes; so it seems and so it is today; but twenty years ago how wild and how fanciful we thought the infection of tuberculosis."

If the private physician will contribute as richly to the program for controlling syphilis as he has contributed to the conquest of tuberculosis, a great shadow will be lifted from the contemporary life of America.

SOCIAL ASPECTS OF MEDICINE

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Dr. Heyd and Dr. Parran have dealt with practical and specific matters—vastly important and immediate in their application. In contrast, my remarks will be in a vein that is more philosophical; I shall deal with generalities. Sometimes it is well, I think, to draw back a little from the details of immediate projects, and in contemplation view medical and social situations in broad perspective, to see trends, and directions, and dimensions.

READJUSTMENTS

And in such a view the feature that shows as peculiar to the present period is the rapid shift and change of long-established social institutions. As we watch these changes, the realization is forced upon us that the body of society is a delicately integrated entity just as is the body of man—so closely knit and interdependent in its parts that a change in any one must necessarily result in a change in all other parts, in a total readjustment. Thus if medical discovery is made and applied to the saving of lives, there must follow a reorganization of society as a whole. The saving of lives results in a change in the age structure of the population. The change in the age structure of the population upsets the balance of established institutions, and necessitates social and economic readjustments. So far the physician sees clearly; but sometimes I think that he fails to see that medicine itself is one of the institutions that is affected by the change. Completing its circuitous course through the social structure, the change eventually comes back to medicine, forcing a readjustment there. Readjustment of medicine is the inevitable consequence of medical progress.

Readjustment is disturbing. We tend to resist it; and resisting it we sometimes get out of step with progress and are left behind. Such resistance is futile; its consequences are destructive.

In previous generations the social structure has been reshaped by wars and pestilences, great national cataclysms in blood and death. But today medicine for the first time has become a primary revolutionizing social force. We are witnessing a reshaping of society arising, not from destruction of lives, but from

the saving of lives. And sometimes the doctor finds himself bewildered by the demands that arise from his own achievements.

Men of the past have never seen a similar humane readjustment of society, but they have seen the possibilities, have speculated on their consequences and feared them. There is a story dating back to the Middle Ages told in many versions that illustrates the embarrassments that come from social readjustment. It is the story of the mountebank who came to the medieval towns and offered, for a fee, to bring back to life the dead in the cemetery. To prove this prowess, he showed testimonials signed by the officials of other towns where, so these documents showed, he had accomplished this miracle. On his arrival at a new town, his offer was at once joyfully accepted; the fee was promised as soon as he had carried out the resurrection.

Wise in his knowledge of the deep-seated desire for social stability, the mountebank promised the miracle at ten days in the future. Ten days was time enough for emotions to cool, and for the people to give sober second thought to the situation. There were widows and widowers who had remarried; there were men and women who had inherited property; and there were long established social relations based upon the age distribution of the living population. In those ten days it gradually dawned upon the people that with the return of the past population, social stability would break down to a degree beyond readjustment. Everyone would be affected, if not by marriage and inheritance, at least by the old people. There would be many of them returning, some as chronic invalids to be cared for, some to sit in the chimney corners, and some to compete with the young. The anticipation of the pleasures of the resurrection gave place to a realization of its dire consequences. As a result, the mountebank—as he had confidently expected—was paid to go away without performing the miracle. In their anxiety to get rid of this threat to their established order, the townspeople gave him a testimonial that he had actually accomplished the resurrection.

In this possibly less credulous age of ours we should scoff at the crude pretensions of such a mountebank; but the fact remains that today we are witnessing the slow development of a social change similar, if not as extensive, to that threatened by the mountebank.

The change is no miracle; it is the result of medical progress and it now brings back to medicine the need for changes in medicine. Let me briefly outline the events.

The starting point is medical advancement; and in the light of history, medical advancement is indeed an unusual state of affairs. The usual situation of medicine is not one of progress, but one of stagnation, a stagnation and complacency in which facts and fallacies are crystalized into thought and effort-saving dogma. There have been centuries, tens of centuries, in which not one single new fact has been gained in the entire field of medicine. Indeed, since recorded history, there have been only two brief periods of medical advancement. The first period occurred during the supremacy of the Greco-Roman civilization. It was mainly philosophical in its import.

The second period began with the Renaissance and revival of learning; it goes on today as the modern period of medical advancement. And the dominant note of this period was, and still is, the acquisition of knowledge, the collection of facts. The peak of this period was reached, I think, in the latter part of the last century with the discovery of the parasitic cause of infectious disease from which grew modern sanitation and the most of modern preventive medicine.

IMPERSONAL SANITATION

Now it so happens that, for reasons that are most fortunate in the light of certain features of medical inertia, most measures of sanitation can be applied without the active participation of the practicing physician. Water purification, sewage disposal, food inspection, quarantine, vaccination, can be made matters of legal regulation and carried out by engineers, sanitarians, and civic health agencies.

The consequences of somewhat less than a hundred years of not too intensively applied preventive medicine have been the enormous diminution in the diseases and deaths of early life—the acute infectious diseases and infant

mortality. As a result, the average length of human life has nearly doubled in this period. The age structure of the population has shifted, and is still shifting. The facts and figures are familiar to you: In 1900 there was one person of sixty years of age or over in every twenty members of the population; in 1930 there was one in every twelve; and by 1960 there may well be one in every six—one-sixth of the population sixty years of age or over. Here, then, is a social and economic problem of vast magnitude in which the first efforts toward solution take the forms of social security legislation and old-age pensions; but these efforts do not touch upon the real problems of old age and retirement in an industrial civilization. They do not touch upon the consequences to medicine.

It is axiomatic in our field that as one disease diminishes, others rise to take its place. As the incidence of tuberculosis, typhoid, dysentery and smallpox go down, cancer and diseases of the circulatory system rise correspondingly. The change in the leading causes of mortality in the last thirty-seven years is commonplace knowledge.

But here is a point that is too often overlooked—a point highly pertinent to the future situation of medicine.

Cancer, diseases of the circulatory system—the diseases of the period past the prime of life that increase today—cannot, nor can they ever, be controlled by such impersonal measures as those of sanitation and general public health which have succeeded with certain acute infectious diseases.

DISCOVERY AND APPLICATION

The diseases that come to the front in the modern medical readjustment are those that can be ameliorated, arrested, cured only by close and intelligent coöperation of the individual members of the public with the physician. Obtaining this coöperation is a vastly different matter from passing laws for sanitation. It is a vastly different matter from acquiring the knowledge of how to prevent or treat the diseases. It is not medical research. It is sociology.

All achieved medical advancement consists of two distinct but inseparable parts. One is strictly medical; it is *research;* it is science; it is the acquisition of the knowledge of the means by which suffering can be assuaged, diseases can be cured or prevented, and life can be prolonged. But this part alone, this knowledge alone, accomplishes none of these things; it eases no suffering, prevents or cures no diseases, and prolongs no lives. These things are accomplished and advancement achieved only when the second necessary part is fulfilled. And that second part is putting the knowledge into use; it is *application.* Application is then for practical purposes as important as discovery. Application is a matter of sociology. To the public and to the physician then sociological extension may be as important as medical research.

Now there are many instances when we have seen the two entirely separated; when we have seen medical discoveries with potentialities of saving health and life, but with none of these potentialities realized. And then after long delay we have seen them put into effect by someone with the convictions of the importance of application.

THE SOCIOLOGIST

The work of Florence Nightingale serves as an example. Her importance was not in giving us technics of trained nursing; Ambrois Paré of the sixteenth century knew those technics as well as she did, and he wrote of them. Physicians had the knowledge, but application was not made. What Florence Nightingale did was to bring about the change in public regard so as to create a public acceptance of and a public demand for nursing. Her work with all its benefits was almost wholly one of application. It was in the field of sociology.

It seems surprising at times—and yet perhaps it isn't—that so many of these medical applications have been made, not by the physician, but by laymen. That was true of the International Red Cross, and it was true of the humane care of the mentally ill. At the turn of the nineteenth century, Dr. Pinel, of France, demonstrated that the mentally ill benefitted from humane care. The matter virtually stopped with the demonstration—with the

knowledge. The physicians of New Jersey did not seize on this knowledge to erect asylums or to change public opinion. No, they waited for the asylums to be erected and public opinion to be changed before they caught up with the advancement. They waited for one of the laiety, a socially-minded Boston school teacher, Dorothea Lynde Dix, to come as an outsider into New Jersey, and in the face of intense opposition, change public opinion and bring about the erection of her first asylum in a total of thirty-two.

Twenty-five years ago every bit of medical discovery was at hand to wipe out syphilis. It is only in the last few years, and particularly this year, that the intensive drive, this time fortunately furthered by socially-minded physicians, has got under way to apply the methods of extermination. The methods are sociological. But why the delay? Application could have been made more than two decades ago and the sacrifice of thousands of lives prevented. Now it either is or is not the duty of the members of the medical profession to be leaders in application as well as discovery. If it is not, then they are technicians: if it is their duty, then these thousands of lives—and many more thousands from other causes—constitute an indictment against the doctor—an indictment of his social neglect.

There can be no other view of the matter. But there are reasons which, if not excuses, are at least explanations of the reluctance of the physician of today to assume leadership in application. They lie in the unfortunate peculiarities of the dominant mode of thought in modern medicine. Medicine in each period of its history has been characterized by a prevailing belief that has shaped the course of medicine. In the days of the Greeks it was *philosophy;* in the Middle Ages—the most sterile period of medicine,—it was subservience to *authority*—the written word settled all problems. In the modern period it is revolt against such authority, but especially it is the *acquisition of new facts.* The emphasis of 400 years has been for the accumulation of knowledge.

We have learned the benefits of movement—advancement in the acquisition of knowledge. But sometimes we forget that there can be inertia, not only in things that are stationary, but even inertia in movement. Such inertia is resistance to change of direction. It has been one of the highly peculiar features of medicine in every age that, once it embarks on a line of movement, it resists with tremendous inertia all efforts to change the direction of the movement. Medicine, and the physician following a direction that has yielded results, stay fast to that direction with fixed attention and dogged disregard of the fact that goals may shift; that situations may alter; that the movement may no longer lead to the desired goals. In the past this phenomenon has occurred time and time again and medicine has dwindled out to futility. It can dwindle out again.

The reason for the mode of thought that pervades medicine today is not hard to find. The acquisition of knowledge must of necessity come before application; it has the primary place both in time and in importance. In the last 100 years, with the introduction of the exact sciences into medicine, medical research has yielded some of the most beneficial knowledge that the human race has ever acquired. Enthusiasm has grown high and a mode of thought crystallized. The science of medicine has been elevated. The art of medicine has been subordinated. The art is the social and sociological aspect of medicine; it is not a science. The doctors of 150 years ago knew the distinction. It was Benjamin Rush who loved mankind even as he loved medicine, who said, "Medicine is my wife and science my mistress." And you may recall Oliver Wendell Holmes' waspish comment, "Medicine may be his wife and science his mistress, but it cannot be shown that the breach of the seventh commandment was of any advantage to the legitimate recipient of his affection." Science was becoming the dominant ideal in the time of Holmes.

If the doctor wants to be a scientist, he may expect to be treated as a scientist. An artist is appreciated by the public; he is revered; the scientist is not. Science to the American public, for all that has been said of it, is not a god; it is a servant. In becoming a scientist, the physician takes his stand with the chemist, the physicist, and the engineer. And the chem-

ist and the physicist and the engineer, for all the good their sciences have done and are doing for our civilization, are not revered; they do not have the social prestige which is essential if the physician is to lead, and not be led, in sociological change.

The overemphasis of the mode of thought that I describe as basic to some of the difficulties of medicine today has been furthered by medical education. We have seen in medical schools the chairs once occupied by great clinicians with wide social interests and wide social influences, filled by scientists. Few great scientists have been outstanding physicians. Harvey, who described the circulation of the blood, was a bad therapeutist; Koch, to whom we owe the conception of the bacterial cause of disease, gave up practice; and Pasteur was not even a physician. Formerly students in our schools were trained to be *socially beneficial*. Now they are trained too often with the apparent intention of making *laboratory investigators* out of them,—and that in spite of the fact that probably not one in ten of the men who graduate from our schools has the peculiarities which would allow him to be an original investigator. Medicine is not an exact science; its practice is a social application.

But the fact remains that this emphasis—or overemphasis—on research has resulted in the development of an aura of sanctity about research. The acquisition of knowledge has received and still receives a cultivated regard amounting almost to a veneration, and one out of all proportion to the regard given to the application of the results of research. This mode of thought, inculcated in the medical student and hence in the physician, has given a direction to medicine. And the movement has developed an inertia so that medicine cannot readily turn to new directions, although those directions are clearly indicated.

Sociological matters—the matters of application—crying in their need today, are, if not in the contempt of the physician, at least not in his highest regard.

The consequence is this:—that here is the physician with his knowledge and his science, and over there is the patient with his disease. The two are separated by a gulf of sociological misunderstanding so wide that there probably exists today a greater space between what *could be done* and what *is done* to control disease and prolong life than at any previous period in history. The physician may know this, he may deplore it, but he is carried on by his own inertia.

SOCIOLOGY IN THE MEDICAL FIELD

But there are others who do not ignore it; who see the needs and are trying to fulfill them. They are mainly from lay groups. And the dangers are that the leadership of medicine will be taken from the hands of the physician.

The social workers of today know that the greatest, indeed, probably the only possible field of social betterment, is offered by medical application. Some aggressive lay groups stand ready to raid the medical field, for its unapplied potentialities. With the natural reaction of newcomers to the field,—unacquainted with its ramifications, but sensing deficiencies,—they assume that there is something basically wrong with the form of medical practice. Their first inclination then is to remake the form of medicine. Today the doctor may take his choice, be led or lead, and the way, whether he is led or whether he leads, lies in the direction he has neglected—sociological change.

The purpose of this sociological change is to cultivate throughout our public a realization of what medicine can do; and to cultivate a cooperation between the public and the physician to do the things that medicine can do. In the last analysis it comes down to this:—the shaping of public opinion to a high regard of medicine and of the physician as its prophet.

Now it is a peculiar fact, but one very evident throughout history, that the regard in which the physician and his calling is held by the public has absolutely nothing to do with the benefits that medicine may confer on the public. Look, if you will, at the medicine-man of uncivilized peoples. From our point of view, all he possessed was a bag of tricks in psychotherapy and a few empirical methods of drug therapy, and yet he was held in a veneration that amounted to actual awe. He was the great leader of his people.

Look next at the physician of the late Middle Ages and the Renaissance. He had more to offer than the savage, but nevertheless he was regarded with no veneration; he was a menial.

And then look at the physician of the late eighteenth century, particularly in this country. That was a period in which men's minds were turned to serious matters. Devotion to principle was a character of that day. Public-minded, socially-minded men devoted their services to the needs of their fellowmen with an almost religious enthusiasm, one of self-sacrifice. They loved medicine; they believed in it with patriotic fervor. They followed medicine as an outlet to give expression to their desire to help their fellowmen. They signed the Declaration of Independence for their country, and were scholarly leaders of its material and social destiny. They may have committed therapeutic mayhem on their patients, but they were men respected by their patients. Their position in the public's mind was far higher than that of the physicians of today, in spite of the fact that what they had to offer as science was negligible.

Now if we look closely at the habits of the physician in these periods in which the regard of him has varied so widely, we find that, when he was venerated, he was a publicist; he was venerated because he believed that he was worthy of veneration; and he convinced the public that he was worthy of veneration.

CHANGING FOLK-WAYS

What he did was shape folk-ways. And there is no greater privilege that may fall to any group of men than that of shaping the ways of their fellowmen. Today we don't call this procedure shaping folk-ways; we call it *propaganda.* And the doctor acquiring the self-protective attitude of the cloistered research worker too often looks down upon propaganda, fears it in spite of the fact that both his interests and the interests of the public depend upon the shaping of folk-ways.

And in regard to this very thing, and to propaganda in general, we are witnessing today a peculiar phenomenon and one that holds potentialities for great good or great evil. We have an enormous number of people in our public who are literate, but uneducated; a public that reads the papers, sees the movies, and listens to the radio. This public does not set its regard of medicine or any other matter upon the judicially weighed merits of the subject. Instead, public opinion is melted by the triumphs of engineering achievement in modern communication, and it is cast almost overnight into the moulds shaped for it by leaders. We have the most unstable society that has ever existed. And today we need leaders—medical leaders who are socially-minded men—men who believe that the medical profession is responsible for application of knowledge as well as the acquisition of knowledge. But before we can have such men, we must be willing to give them and their efforts our respect and our support. And in the way of this respect and support stands the belief too often held by the physician that application is far less important than acquisition of knowledge.

Public opinion for good or for bad is shaped by propaganda. People use one toothpaste or another, not because of the merits of the products, but because of propaganda. It is propaganda, not benefit, that made the Hay diet popular; propaganda has popularized all the fads and all the fallacies. Have you ever stopped to think why the public, on the one hand, learns so quickly of any food discovery and, on the other, so slowly of some medical measure, say, the need for early diagnosis in the control of cancer? The food discoveries are popularized by food manufacturers for commercial interest. Commercial interests know the value of propaganda. Discover a new vitamin today, and tomorrow it will be in beer or bread, and the day after the technical terminology of the nutrition laboratory will roll glibly off the tongues of 100,000,000 people; the same 100,000,000 people who think that cancer is a shameful disease, and who mention syphilis only in euphemisms.

Now I grant you that medical societies have begun to have an inkling of the importance of propaganda. But usually it is not a deep interest; merely something that the members feel can be dismissed by appointing some man or some committee to handle such so-called public

relations—a man or a committee overworked, inadequately supported, embarrassed, and restrained. Or perhaps it decides to give a few talks on the radio, or put a few articles in the paper in an amateurish and purile attempt to broadcast dubious rules of hygiene rather than shape public opinion.

POWER OF SOCIAL CLUBS

To my mind, these are not the directions that can lead to success. The doctor with the pressure of his duties has not the time to devote to intensive propaganda. But if he will only realize it, he has at his very hand, willing agents who will do the work for him. And those willing agents are the *socially-minded laymen*, some of whom practice social service work professionally, and some as amateurs; but far more are those who have the desire but not the knowledge. Many are organized in clubs that are willing and ready to work as a group for a purpose. I say to you, don't have contempt for the strength of women's clubs, luncheon clubs, and church organizations. They are powers to be used.

With that old distinction between the profession and the laity still strong in the medical mind, the doctor has by and large scorned the help that is offered to him. Mutual antagonisms even have grown up. There was a time when a cultivated professional distinction was necessary; the doctor lacking valid methods was forced to hide his ignorance behind a show of artificiality; to write his prescriptions in bad Latin; to refuse to explain anything to his patient. Today he no longer needs to hide his methods or his knowledge. Medical practice has become far too technical for lay immitation. But there are directions in which the laity can help and will help if the physicians will give them some respect and some responsibility so that they may feel the importance of their efforts.

Ready to the physician's aid, if he will unbend and graciously solicit them, are some 500,000 intelligent, public-minded, socially active, enthusiastic, but as yet undirected, laymen who want to feel that they lead toward social betterment. Let the physician take the time, make the effort to lead them, lay out for them a plan, convert them and instruct them, and they in turn will lead, convert and instruct the whole of the American public. Let them be your agents in shaping the medical folkways of the American public.

THE PHYSICIAN HIMSELF

But before this can be accomplished there must come a change in the attitude of the physician. He must get over his own inertia of movement, his fetish of research; and learn to believe in the necessity of application, in the dignity of propaganda, and in the medical influence of the laity.

Now I have talked tonight of the public's regard of medicine, but in doing so I have not stressed one point—perhaps the most important one:—the physician himself is a product, a part of the public. He has grown from it, his ideas and his ideals are colored by it. The state of the practice of medicine in any period reflects the state of the public; the public's attitude toward medicine reflects in turn precisely the regard in which the physician himself holds his own calling. When the physician regards his calling as a trade, he is treated as a tradesman.

When he holds it as a science, he is treated as a scientist.

When he holds it as a public duty, to be given his devotion, then and then only is he respected as a leader of the public.

ABDOMINAL EMERGENCIES ASSOCIATED WITH MECKEL'S DIVERTICULUM

REPORT OF A CASE

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Fetal structures persistent in the mature individual are prone to initiate pathological processes. This fact is well illustrated in the case of the omphalomesenteric or vitelline duct. In the fetus this duct extends from that portion of the small bowel known as the mid-gut to the umbilicus. It normally disappears from the fourth to the seventh week of fetal life, but some remnant is present in about two per cent of individuals.

The nature of the remnant depends upon the degree of evolution of the duct. Three forms have been described.

1. The duct may persist as a mucous-lined tube extending from the ileum to the umbilicus, forming a fecal fistula.

2. There may be a fibrous band attached to the ileum and hanging free in the peritoneal cavity, or attached at the distal end to the umbilicus.

3. Most frequently the duct remains patent in part. If this occurs at the outer end, a mucous-lined sinus, opening and discharging at the umbilicus, will result. Rarely only the central portion of the duct may remain patent, forming a mucous cyst, suspended by a fibrous cord from the ileum, or umbilicus, or both. Most frequently only the inner end of the duct at the ileum persists, resulting in a diverticulum, which was first described by Johann Friedrich Meckel in 1813.

Meckel's diverticulum opens into the antimesenteric border of the small intestine at some point varying from 0.2 to 1.0 metre proximal to the ileo-cecal junction. It may vary in length from 3 to 75 cm. It is distinguished from most false diverticula by consisting of all the coats of the bowel. Strangely enough, it often contains islands of ectopic tissue, such as pancreatic glands or gastric mucosa.

Pathological processes affecting Meckel's diverticulum may be considered under four groups, namely, peptic ulcer, intestinal obstruction, diverticulitis, and tumor formation.

ULCER

Ulcer of Meckel's diverticulum is the most frequent pathological condition in this vestige. The finding of gastric mucosa in the lining of many diverticula probably has a significant relationship to ulcer formation. The aberrant mucosa is usually located near the tip of the diverticulum. Ulcers are of the acute type, having sharply demarcated margins. Their tendency to bleed and perforate produces signs and symptoms that point to their presence.

INTESTINAL OBSTRUCTION

Intestinal obstruction is occasionally due to Meckel's diverticulum. Several different mechanisms have been observed. The diverticulum may become adherent to a loop of ileum and cause an obstructive kink. Or the structure may become incarcerated or strangulated in a hernial sac. The most common mechanism is intussusception, which begins by inversion of the diverticulum. The symptom complex in all these forms is that of mechanical ileus. In many cases blood is present in the stools.

INFLAMMATION

Inflammation in Meckel's diverticulum, often improperly called Meckel's diverticulitis, may be primary or secondary. In the primary type the pathological changes are similar to those occurring in appendicitis. The secondary type follows constriction or strangulation, as when the diverticulum becomes twisted, or is caught in a hernial sac. In both types, perforation, abscess formation, or diffuse peritonitis may follow. The clinical picture of diverticulitis, except for the cases which result from strangu-

lated hernia, resembles appendicitis so closely that differentiation is usually impossible.

TUMOR FORMATION

Tumor formation in Meckel's diverticulum is a rare condition. Myoma, sarcoma, carcinoid, and carcinomatous tumors have been found. The clinical picture in these cases is that of partial obstruction of the bowel, with constipation, abdominal pain, and perhaps a palpable mass.

FREQUENCY OF MANIFESTATIONS

A group of 201 cases of acute abdominal emergencies caused by Meckel's diverticulum has been collected from the recent literature by Miller and Wallace. A brief summary is quoted here to give an idea of the relative incidence of the pathological processes just described. Ulcers, with hemorrhage or perforation or both, occurred in 93 of the 201 cases. Intussusception was present in 63; and other forms of intestinal obstruction in 26 cases. Acute inflammation or diverticulitis occurred in only ten cases. Tumors and miscellaneous processes were present in nine of the 201 cases.

CASE REPORT

A patient, R. M., white male, aged four years, was admitted to Cooper Hospital, October 31, 1936, on the surgical service of the senior author. His chief complaint was abdominal pain of about thirty hours' duration. Before this he had seemed perfectly well. Soon after the onset of pain his mother gave him an enema with no result. Later the child began to vomit, and the emesis persisted at intervals until the time of admission. Meanwhile a second and a third enema were given, and a small evacuation was obtained by the third enema. About two hours before admission he was given a dose of milk of magnesia, which he promptly vomited. The pain seemed to be of a severe colicky type.

His past history was negative except for whooping cough in 1934, and measles in 1935, and a couple of attacks of tonsillitis.

Physical examination revealed a well-nourished lad apparently four years of age. The tongue was heavily coated. The cardio-vascular and respiratory systems were negative. The abdomen was symmetrical and not distended. Respiratory excursions were present, but limited on the right side. There was definite rigidity in the right lower abdominal quadrant, and marked tenderness to moderate pressure over McBurney's point, and some tenderness to pressure elsewhere. The sigmoid pressure sign was negative. The child indicated that his greatest pain was at a point just below and to the right of the umbilicus. His temperature was 99.4 degrees F., pulse rate 100 per minute, and respiratory rate 24 per minute.

Upon these findings a diagnosis of acute appendicitis was made.

About an hour after admission, the patient was operated on under general anaesthesia. A McBurney's incision was made in the lower right quadrant. A moderate amount of clotted blood was found free in the peritoneal cavity. The appendix was inflamed, but not ruptured. To secure adequate exposure and determine the origin of the free blood, a mid-line incision was made. A Meckel's diverticulum was found about 35 cm. from the ileo-cecal valve. It appeared to be gangrenous, and was perforated at one point. It was clamped at the base and amputated with a knife. The remaining hole in the bowel—about two cm. in diameter—was sutured transversely with an atraumatic needle. An ileostomy was performed about 20 cm. proximal to the diverticulum—the end of the catheter being in the direction of the fecal current. The appendix was removed in the usual manner, and both incisions were closed in layers.

Post-operative diagnosis was acute appendicitis, and acute inflammation of Meckel's diverticulum, with perforation and intraperitoneal hemorrhage.

The convalescence was stormy. For the first five days fluids were given intravenously, by hypodermoclysis, and chiefly by a Murphy drip through the ileostomy tube. On the second day, Wangensteen drainage was started because of vomiting. This was discontinued on the fourth day.

For the first five days the temperature ranged from 103 to 105.6 degrees F.; pulse 120 to 180; and respirations 20 to 30. On the fourth day the respiratory rate began to ascend, and the patient was placed in an oxygen tent. Due to clinical improvement, this was discontinued on the eighth day, and at this time a bedside x-ray of the lungs showed an area of consolidation in the medial and upper quadrants of the upper right lobe. Five days later an x-ray of the chest showed the lungs to be clear. On the fourth day a series of prostigmine injections was given, and bowel movements started. The ileostomy tube was removed on the eighth day. The temperature, pulse, and respirations gradually leveled off to normal, and in twenty-six days after admission, the patient was discharged in good condition.

The pathological findings are interesting. The appendix measured seven cm. There was serosal congestion, and scattered mucosal hemorrhages. Microscopically, there was hypertrophy of lymphoid tissue, and scattered areas of hemorrhage. The muscularis was thin and showed polymorphonuclear infiltration.

The diverticulum measured 5, by 3, by 2.5 cm. A longitudinal section revealed that the mucosa lining it was of two types. That lining the proximal one-half measured 1.0 mm. in thickness, and had a number of transverse folds. That lining the distal half was 2.0 mm. in thickness, and had fewer folds. Microscopic sections of the thinner mucosa showed that it closely resembled normal ileum; and sec-

tions of the thicker mucosa showed that it closely resembled normal duodenum. The mucosal glands were similar to crypts of Lieberkuhn, with indefinite suggestion of acidophilic and basophilic cells. Glands resembling Brunner's submucosal glands of the duodenum were observed.

It was also noticed on the gross specimen that there was an area about 1.0 cm. long where the mucosa was apparently absent. A section through this area showed an inflammatory process involving the entire thickness of the wall. It consisted of fibrous and granulation tissue, and necrotic and fibrinous exudate. There was extensive polymorphonuclear and round cell infiltration. There were numerous areas of hemorrhage.

At one point in the section a channel was seen extending from the lumen of the diverticulum to the outside. The walls of this channel were lined with a thick layer of cellular and fibrinous exudate, and this was thought to be the site of perforation. No inflammatory reaction was noted in the remainder of the diverticulum. The pathologist interpreted these findings as an acute ulcer.

So the final diagnosis of this case stands as coincidental occurrence of acute appendicitis and perforated peptic ulcer of Meckel's diverticulum.

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3. Miller and Wallace: Meckel's Diverticulum in Acute Abdominal Emergencies. Annals of Surgery, 98:713. October, 1933.
4. Wolfson and Kaufman: Acute Inflammation of Meckel's Diverticulum. Annals of Surgery, 89:535. April, 1929.

ECTOPIC PREGNANCY

MATERNAL WELFARE ARTICLE NUMBER SIXTEEN

By Edward G. Waters, M.D., F.A.C.S.

Assistant Professor of Clinical Obstetrics and Gynecology, Graduate Medicine, Columbia University

While one may question whether the field involved in ectopic pregnancy is surgery, gynecology, or obstetrics, we know that the usual management and final solution of the problem is surgical. Ectopic pregnancy is one in which the nidation and growth of the fertilized ovum takes place outside of the uterine cavity. The incidence is about one in four hundred cases. It occurs in all types of women irrespective of race, is usually seen in the first ten years of married life, and therefore in younger women, and is commonly noted after long periods of sterility.

ETIOLOGY

The etiologic factors are not only varied but in a considerable number of cases are not determinable. The production of ectopic pregnancy is obviously dependent upon the introduction of factors which cause an arrest in the transmission of the fertilized ovum to the uterine cavity. Such factors may be intrinsic, as with post-inflammatory alteration of the tubal lining; or extrinsic, such as interference through constricting or kinking pelvic inflammatory adhesions, pelvic tumors, ovarian cysts, and the like. Even after exhaustive search there still remain some thirty to forty-five per cent in which no discoverable cause is found.

ECTOPIC LIFE OF THE OVUM

The early ectopic life of the developing ovum is of interest. While the Fallopian tubes and uterine body are genetically identical, there is a very important difference in their anatomic structure. While neither possesses a true submucosal layer, the muscular wall of the uterus is well protected by a fairly thick connective tissue stroma which undergoes a rather marked increase in thickness when conception takes place.

The tube possesses no such structure. Nor does it ever develop a well-formed decidua and such as forms is generally digested by the trophoblastic layer near the site of ovum implantation. There is frequently no true decidua formation at all; and the pseudo-decidua which is seen consists of fibrin, connective tissue, and the invading ectodermal cells.

The rapidly developing fertilized ovum, arrested in its transmission toward the uterine cavity, attaches itself to the mucosa from which

it draws nourishment. The syncytial cells of the trophoblastic layer erode the mucosa by phagocytic action, and the ovum thus comes to lie within the mucosa, and directly upon the muscularis. The protective connective tissue layer as seen in the uterus is absent, and the villi of the chorion directly penetrate the muscularis of the tube. Except for excessive hemorrhage about the ovum as it imbeds itself in the tubal wall, the nidation is closely akin to that seen in the uterus. An abortive attempt is made by the tube to set up active connective tissue reaction, but the scanty stroma formed offers little protection to the tubal musculature. This is soon invaded by villi, and the picture presently seen is that of a mass of trophoblastic cells and fibrin surrounding the gestation sac; invasion of the musculature of the tube itself by trophoblastic cell groups; defective or absent decidua; an excessive amount of blood surrounding the ovum with invasion not only of the wall but of the tubal vessels by the trophoblastic cells; and marked distension of the tube at the site of implantation, with slight connective tissue reaction.

Unless this state of affairs is diagnosed clinically and the product of conception removed, one of the following must happen: An invasion and rupture of the pseudo-capsular decidua with abortion of the conception product into the tube, where it may die or be aborted into the abdominal cavity as a secondary abdominal pregnancy; or rupture of the tubal wall, which is the common sequence. There may be a sudden rupture through a large vessel, giving the classical picture of collapse and early death; but more usually there is a gradual hemorrhage into the tubal lumen, resulting in a hematosalpynx with an escape of blood through the fibriated end, and formation of clots and considerable amounts of free blood in the peritoneal cavity. Rarely rupture takes place through the aperitonealized surface of the tube, and the products of conception are thrust between the leaves of the broad ligament instead of the peritoneal cavity.

UTERINE CHANGES

While ineffective alterations are taking place in the tube at the behest of the parasitic ovum, certain uterine changes are also evident. The uterus is always enlarged, although it seldom reaches the degree which it would were the pregnancy intra- rather than extra-uterine. The change in size is apparently due to hyperemia and thickening of the endometrium, and some increase in the size of the muscle fibres. Contractions initiated in the tube are transmitted to the uterus, and are expressed as labor pains, frequently thrusting out a portion of the decidua. This is almost always dependent upon embryonic death, for uterine bleeding is seldom present or marked if the fetus is living. The blood does not come from the tube as is erroneously thought, but from the congested veins of the uterine mucosa.

The expression of sympathetic uterine labor pains results in an expulsion of the uterine decidua vera, extruded frequently in the form of a decidual cast. This is found on examination in nearly half of all true cases of ectopic pregnancy. The close examination of this cast is highly important, for by inspection one may determine whether or not the product of conception was uterine. However, the cast must be complete and fail to contain chorionic villi in any and all of its parts in order to positively state that the pregnancy is extra- and not intra-uterine. It is obviously possible for a uterine pregnancy to abort, and have non-villi containing decidua vera extruded.

LOCATIONS OF TUBAL PREGNANCY

The various locations of tubal pregnancy are given as fimbrial, ampulary, isthmial, and interstitial, or cornual. While the fimbrial and ampulary locations of tubal pregnancies are subject to gradual leaking of blood into the abdominal cavity with gradual expulsion of the embryo, and on occasion, secondary abdominal pregnancies, the isthmial or central type is more apt to rupture directly and suddenly into the abdominal cavity.

The cornual type, however, is of considerably greater importance than any of the others, although fortunately much less frequent and constituting only about three per cent of the total number. Here we have the anastomotic connection between the uterine arteries and the ovarian vessels; and when rupture takes

place a very profuse and continued hemorrhage occurs, causing the most dramatic onset of symptoms, and all too frequently very sudden death of the patient.

Abdominal, ovarian, and tubo-ovarian pregnancies are such unusual forms of ectopic gestation that they will not be referred to further in this paper.

DIAGNOSIS

The *diagnosis* of ectopic tubal pregnancy, while always difficult, is made possible by thorough appreciation of the foregoing. The picture presented by sudden tubal rupture with accompanying extensive hemorrhage is so obvious that it cannot fail of recognition. More commonly, however, this dramatic accident follows a train of symptoms which have been neglected often by both patient and physician.

The common history is of *a missed menstrual period* in a patient whose menstruation had been previously normal. Secondary breast signs, urinary frequency, and digestive disturbances are often noted. A majority of these patients suspect themselves to be pregnant, although a few are totally unaware of the possibility until something happens.

After a passage of six to eight weeks, some *abnormal vaginal bleeding* is noted, which comes from the congested uterine mucosa. If the fetus in the tube has aborted or died, the bleeding is more marked. A feeling of congestion or heaviness in the pelvis is noted; and is frequently more marked on the affected side, and followed by *recurrent sharp* and *cramp-like pains*. The pain is due to three things: First, the tearing and stretching of the serous covering of the tube by the growing fetal mass; second, by the peritoneal irritation from expelled blood; and third, by the exaggerated tubal peristalsis which is transmitted to and sets up uterine contractions. Two-thirds of all patients seen have some type of vaginal bleeding occurring at a time other than her normal menstrual cycle would be.

In one-fourth of the patients there is a history of *syncope,* which is a valuable symptom when associated with lower abdominal cramp-like pain or bleeding.

The *general appearance* of the patient depends largely upon the amount of internal hemorrhage. If it is large, she will show all of the signs of internal hemorrhage associated with the rupture of a large intraäbdominal vessel. The spilling of blood into the peritoneal cavity sets up an irritative peritonitis, with added pain upon voiding and defecation. This irritative pertonitis causes marked *tenderness* in four out of five cases, the point of greatest sensitivity being found over the affected area.

Rigidity is also seen in two out of five cases, but when some time has passed it is masked by abdominal distension. It is likewise dependent, to a considerable degree, upon the development of the lower abdominal muscles.

Upon *pelvic examination* unbearable pain is elicited, in about half of the cases, upon palpating the cervix. Pressure upon the cervix causes change in tension of the broad ligaments, with correspondingly increased irritation of the affected region. The enlargement of the uterus is also noted as not corresponding to the estimated duration of the pregnancy, and the tenderness in the fornix on the affected side is abnormally great.

LABORATORY FINDINGS

The *laboratory* is of considerable assistance, but is much less important than an accurate history and careful physical examination. The white blood cell count will rise as long as hemorrhage continues, but is normal in at least half of the cases. The hemoglobin content and red cell count is of little value, for the compensatory systemic effort to maintain blood pressure precedes blood dilution.

Hematocrit determinations are of much greater value. The hemoglobin may be fairly high even when active hemorrhage is taking place, although when bleeding has gone on for hours, or a slow leak has taken place for days, a low hemoglobin reading may help in the diagnosis. The important point is not to be mislead by high hemoglobin content. The sedimentation time, if there is free blood in the abdominal cavity, is like that found in pelvic inflammatory disease. The Ascheim-Zondek test is usually positive if one can wait for it.

While in the severe shock associated with the dramatic form of tubal rupture, the tem-

perature may be subnormal, it is more usually normal or elevated, dependent upon peritoneal irritation after rupture.

Certain signs, such as dullness in the flanks, a palpable abdominal mass, Cullen's sign, and increased pallor of the cervix, are too infrequently seen and too indefinite when present to be given much weight. The danger of posterior colpotomy or needling of the cul-de-sac too definitely outweighs the potential value to warrant its use.

TREATMENT

Any patient suspected of having an *unruptured tubal pregnancy* is immediately put to bed, and prophylactic procedures carried out. Her blood type is noted, and available donors procured. A thorough attempt to positively determine the diagnosis, and a careful estimate of her general condition, are then made. A laparotomy is performed, and the tube containing the pregnancy is removed.

There is one cardinal rule in treating *ruptured ectopics*. That is: NO SURGERY UNTIL RECOVERY FROM SHOCK AND HEMORRHAGE. There is no excuse for a reckless and hurried, even though lucky, operation. Huge and persistent intraäbdominal hemorrhage from ruptured interstitial pregnancy requires volumetric blood replacement with homologous blood, operation to stop bleeding, and further postoperative blood replacement.

The operative deaths are most apt to occur in those patients who have bled themselves to the "shock pitch" point, where the compensating factors of peripheral vasoconstriction, increased systolic effort, and lymph replacement are exhausted. The appearance and blood pressure of the patient must not mislead the surgeon, for she may be on the verge of lethal shock. *The blood volume must be replaced by blood.* Until this is available, 10 per cent glucose in 1000 c.c. saline solution, or 500 c.c. of two per cent hypertonic saline are valuable expedients, with one c.c. adrenalin added per 1000 c.c. Six per cent gum-acacia in 20 per cent glucose, in 300-500 c.c. amounts, is very valuable and safe, if properly prepared and given slowly.

Trendelenberg posture is used to combat anemia of the higher centers and prevent further splanchnic stasis. External heat restores body temperature, and warm moist air checks pulmonary heat loss. Injections of pantopon or morphine are given in sufficient doses to obtain pain relief and mental rest. Six-ounce hot coffee retention enemas are useful, especially post-operative.

When the blood volume and blood pressure have been restored, and the patient is definitely secure from hemorrhagic shock, laparotomy must be proceeded with and the operation consummated in the quickest and safest way possigle. The anaesthesia may be one of the gases as cyclopropane, gas-oxygen, or ethlylene, or local, or spinal, depending upon the training and adeptness of the anaesthetist and surgeon. But it must *never* be ether, unless one wishes a doubled mortality rate.

CONCLUSIONS

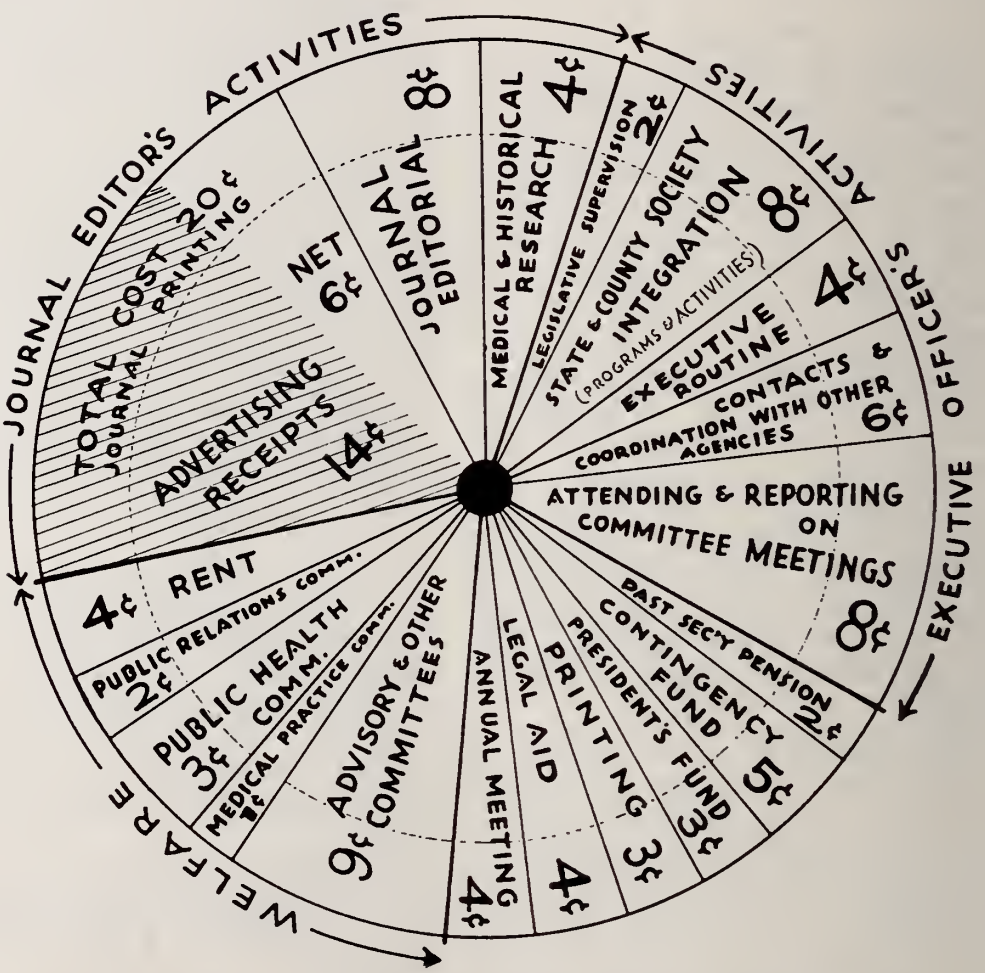
1. Proper conception of the basic pathology of ectopic pregnancy explains the symptoms and leads to more certain diagnoses.
2. *Blood volume replacement is urgent; surgery is not emergent.*
3. Treatment for blood loss and shock must precede every operation. There are no exceptions!
4. Adequate pre-operative therapy, conservative surgery, proper choice of anaesthesia, and post-operative shock precautions, warrant good results.

39 Gifford Avenue
Jersey City, N. J.

STATE SOCIETY ACTIVITIES

THE ANUNAL BUDGET, EXPENSES AND DUES

By WILLIAM G. HERRMAN, M.D., Asbury Park, N. J.
President, The Medical Society of New Jersey



HOW EACH DOLLAR OF INCOME OF THE STATE SOCIETY IS BUDGETED
The outer circle represents the budget that was adopted by the House of Delegates. The dotted inner circle indicates the dues that are levied on the individual members.

In view of the discussion that occurred during the Annual Meeting in regard to the budget and the financial status of the Society, it seems pertinent for the President to give to the membership of the Society, in his first letter, some idea of the budget appropriation and for what each member is contributing his dues.

We have therefore had prepared a diagram which allocates the budget and the dues of the individual member. We also feel that the general membership should be appraised of the large contribution in time by officers and committee members of both the State and county societies which is not paid for.

The budget shows the amounts approved by the House of Delegates which *may be* spent for the activities of The Medical Society of New Jersey. We are operating under a budget system, therefore the budget must be made sufficiently large to include both anticipated and possibly unanticipated expenditures. If the budget is drawn too closely, worthwhile activities of the Society may be hamstrung because funds are not available. This does not mean that all the money appropriated in the budget will be used. Generally it is not. The outer circle of the diagram indicates the total budget amounting to $66,680.00. The inner circle indicates the amount of money raised by dues, which sum is $17,180.00 *less* than the budget estimate. If we contemplate the possibility of spending more money than is raised by dues, how will the difference be made up? This deficit, if accumulated, will come out of the income from the advertising in the Journal and technical exhibits at the Annual Meeting, and surplus left over from the previous year's unexpended budget. Where such a surplus is realized because the expenditures of the preceding year did not reach the budget, the Budget and Finance Committee use this surplus to keep the dues as low as possible. The dues previous to this year have been $13.00 a year for a number of years, and in many cases have been insufficient to meet the budget even when the income from the Journal and of the technical exhibits has been added thereto, the difference in each case being made up by any cash surplus carried over from the previous year. In estimating the budget for this year there were so many new and increased activities contemplated that the budget had to be materially increased. For this reason it was felt necessary to increase the individual dues to $15.00, although here again this by no means meets the requirement of the Society.

We have attempted drawing the segments of the circles to give as close an indication as possible as to the proportion of allotment to the various activities. It should be remembered, in studying the chart, that while the Journal apparently occupies a large proportion of the circle, it itself is a money maker and helps to materially keep down the size of the dues.

Your President felt it advisable to add to this brief discussion of the budget and the dues the following compilation of the unpaid-for services of State officers, Trustees and committees. Each one of these men is giving gladly of his time to the service of your Society, in addition to paying himself $15.00 per year which each other member of the Society contributes.

FINANCIAL EQUIVALENT ESTIMATED FOR STATE OFFICERS, TRUSTEES AND COMMITTEES

(Figured at $5.00 per hour and total hours per year)

6	Cabinet Officers	2,160 hours	$ 10,800
1	Secretary	200 hours	1,000
1	Treasurer	200 hours	1,000
17	Trustees	340 hours	1,700
56	Welfare Committee	840 hours	4,200
23	Chairmen of committees	2,300 hours	11,500
5	Committee chairmen (Welfare and four sub-committee Chairmen)	1,250 hours	6,250
171	Committee members	17,100 hours	85,500
5	Judicial Councilors	125 hours	625
	Total State Society Free Services		$122,575
84	County Society Officers	8,400 hours	42,000
1000	County committee members	5,000 hours	25,000
	Total County Society free services		$ 67,000
	Grand Total—Minimum value of free services		$189,575

I know you will agree with me, that when we attempt to estimate the value of these services in dollars, we are by no means adequately estimating their value, when we set a price of $5.00 an hour for such services.

The House of Delegates authorized the Board of Trustees to engage an accountant to open up a set of books for us that will, at any time, enable those interested to know exactly what our financial set-up is. The Society has grown so much in its activities and expenditures that this is not only desirable but quite necessary.

ANNUAL REPORT OF THE TREASURER FOR THE FISCAL YEAR 1936-1937

PERMANENT FUND

May 31, 1936—	
2M U. S. Treasury 3¼% bonds of 1943-5	$ 1,997.50
1M U. S. Treasury 3¼% bond of 1944-6	1,034.38
1M U. S. Treasury 3% bond of 1946-8	1,014.06
Mortgage Certificates, Investors Title & Mortgage Co.	3,000.00
Mortgage Certificates, Trenton Mort. & Title Guar. Co.	2,625.00
Savings Account, First National Bank of Paterson	5,394.31
	$15,065.25
May 31, 1937—	
2M U. S. Treasury 3¼% bonds of 1943-5	$ 1,997.50
1M U. S. Treasury 3¼% bond of 1944-6	1,034.38
1M U. S. Treasury 3% bond of 1946-8	1,014.06
Mortgage Certificates, Investors Title & Mort. Guar. Co.	2,910.00
24-15/100 shares, Trenton Mortgage Service Co.	2,415.00
Savings Account, First National Bank of Paterson	5,694.31
	$15,065.25

CHARLES J. KIPP MEMORIAL FUND

(Eye, Ear, and Throat Section)

May 31, 1936—	
Deposit, Howard Savings Institution	$30.00
May 31, 1937—	
Deposit, Howard Savings Institution	30.00

GENERAL ACCOUNT

RECEIPTS

Balance, May 31, 1936		$ 43,867.65
Assessment—		
Atlantic	$ 1,612.00	
Bergen	2,999.75	
Burlington	728.00	
Camden	2,327.00	
Cape May	312.00	
Cumberland	715.00	
Essex	11,326.50	
Gloucester	533.00	
Hudson	5,720.00	
Hunterdon	325.00	
Mercer	2,600.00	
Middlesex	1,513.00	
Monmouth	1,875.25	
Morris	1,378.00	
Ocean	325.00	
Passaic	4,433.00	
Salem	260.00	
Somerset	728.00	
Sussex	273.00	
Union	4,004.00	
Warren	455.00	
		44,447.50
Publication receipts		9,895.09
Interest		782.33
Commercial Exhibits, Annual Meeting, 1936		2,770.00
Commercial Exhibits, Annual Meeting, 1937		2,283.23
Miscellaneous		43.80
		$104,089 60

PAYMENTS

For Publication Committee		$ 14,396.58
" Salaries:		
Secretary	$1,375.00	
Executive Officer	6,000.00	
Executive Officer, bonus	1,000.00	
Editor	5,000.00	
		13,375.00
" Office operation:		
Clerical services	$5,353.00	
Operating expenses	832.65	
Travel	615.64	
Furniture and equipment	646.11	
Liability insurance	143.64	
Moving	69.50	
Rent	1,284.38	
		8,944.92
" Expenses of officers:		
President	$1,881.30	
Secretary	2,093.11	
Treasurer	99.80	
		4,074.21
" Committees:		
Welfare	$1,090.23	
Public Health	2,110.41	
Public Relations	699.32	
Trustees	240.45	
Judicial Council	118.13	
Medical Practice	229.76	
Other committees	139.75	
		4,628.05
" Annual Meeting, 1936:		
Program & arrangements	$1,185.87	
Credentials Committee	529.09	
Scientific Exhibit	2,728.65	
Scientific Work Committee	131.75	
Executive Office	133.03	
Woman's Auxiliary	367.56	
Arts & Hobbies Committee	91.16	
Guests	267.27	
		5,434.38
" Printing and stationery		1,916.68
" Legal services and expenses		2,133.46
" A. M. A. Delegates, railroad fares		435.70
" President's educational letters		1,019.98
" Tri-State Medical Directory		865.85
" Woman's Auxiliary, for A. M. A. meeting		400.00
" Increasing office cash fund		500.00
" Conference of Allied Medical Professions		25.00
" Miscellaneous		130.07
" Annual Meeting, 1937; advance to new budget		1,288.10
Balance, May 31, 1937		44,521.62
		$104,089.60

BUDGET RECONCILIATION

Expected income	$55,800.00
Actual receipts	60,221.95
Budget appropriations	57,260.00
Expenditures	59,567.98
Operating net balance	653.97

Respectfully submitted,

E. J. MARSH, M.D., *Treasurer.*

A BRIEF RESUME OF ASTHMA, ITS SYMPTOMS AND TREATMENT

An introduction to the prescriptions on pages 394 and 395.

Asthma is a syndrome of many theories, and many underlying conditions may give rise to it.

The word "asthma" is not easy to define. Many theories of etiology and mechanism have given origin to many definitions, none of which is generally accepted. In his admirable discussion of asthma, Matthew Walzer says: "Bronchial asthma may therefore be defined as that form of atopic illness which manifests itself in recurrent attacks of paroxysmal dyspnea, particularly pronounced in the expiratory phase." By inserting the word "atopic", Walzer segregates "bronchial asthma" from the so-called thymic, renal, and cardiac asthmas, as well as from those forms of chronic bronchitis and emphysema which symptomatically simulate bronchial asthma. The word "atopic" is applied to certain clinical forms of hypersensitiveness that do not occur, so far as is known, in the lower animals, and that are to some extent hereditary.

Deaths from asthma are relatively few, and autopsies upon asthmatic patients have not disclosed a definite pathologic entity.

FOR PROMPT RELIEF

The need for immediate symptomatic relief is imperative. Sub-cutaneous injection of 0.5 to 1 cc. of epinephrine solution 1:1000 is promptly effective, and usually affords relief for a period of from thirty minutes to two hours or longer. Walzer says: "There is no agent which will alleviate an attack of asthma with greater rapidity and effectiveness, and with less disadvantage to the patient, than epinephrine, or, as it is more frequently called, adrenalin. It is a natural substance, the active principle of the medulla of the adrenal gland, but it can now be prepared synthetically."

Few drugs exert more prompt or beneficial effect in any condition than adrenalin does when administered during an asthmatic seizure. Cohen and Rudolph comment as follows: "The effect of this drug on a patient in an attack of asthma is startling when observed for the first time. Within five to fifteen minutes after the subcutaneous injection of a suitable dose the paroxysm begins to subside and usually within thirty minutes it has completely disappeared. The effect following subcutaneous administration lasts for from thirty minutes to two hours."

SYMPTOMS SOMETIMES RECUR

"Patients having severe attacks will have a recurrence of symptoms in a few hours. For these it is well to observe the frequency of recurrence and to administer a dose of epinephrine just before the next attack begins or on its inception. Often the administration of 0.3 cc. of the 1:1000 solution every three or four hours, day and night, will prevent the symptoms completely, and less of the drug will be needed than if one waits for the attack to be full-blown before giving it. The authors conclude this discussion by saying: "When given properly, epinephrine is the most valuable remedy that we possess for relief of the acute asthmatic paroxysm."

RENEWAL OF ADRENALIN EFFECT

From a paper by Luckhardt and Koppanyi it would appear that the reason why the effect of adrenalin on the blood pressure when the 1:1000 solution is injected hypodermically is of such comparatively short duration is that it is "cached", so to speak, in the subcutaneous tissues; for, by massaging the area of injection from time to time after the pressor effect declines, it is possible to renew that effect; one injection of adrenalin was thus rendered effective for nineteen hours. Dr. H. Lilienthal, of New York, acting on this suggestive observation, tried the effect of massage after epinephrine injection in three cases of asthma and one case of shock. His results were good; in one case occasional massage maintained the effect for as long as forty-eight hours. This simple measure often obviates the necessity of frequent injections. The patient can massage the site himself.

The publication of Timely Prescriptions in alternate months will be continued, but they will appear in the body of The Journal instead of on a cardboard insert. The Committee plans to collect and publish the prescriptions in a booklet to be entitled "The New Jersey Formulary".

JOINT COMMITTEE ON PROFESSIONAL RELATIONS

Medical Society

Chester I. Ulmer, M.D., *Chairman*
Samuel Barbash, M.D.
Merwin L. Hummel, M.D.
Sigurd W. Johnsen, M.D.
Alvin E. Kuhlmann, M.D.

Pharmaceutical Association

Henry D. Kehr, *Chairman*
Carl C. Christensen
Robert P. Fischelis
Adolph Marquier
George C. Schicks
C. Hayden A. Streamer

NON-SPECIFIC HAY FEVER TREATMENT

Prescription No. 49 **Syrup of Ephedrine Sulfate**

℞

	Metric	*Apoth.*
Syr. Ephedrinae Sulfatis, N. F.....	180. cc.	f ℥ vi

Sig: ℥ i two to four times a day.

Note: Each teaspoonful contains approximately:
Ephedrine Sulfate gr. ¼ or .016 Gm.
Distilled Water
Alcohol
Syrup of Cherry q.s.
Untoward effects to be watched for are:
Nervousness, giddiness, headache, sleeplessness, dysuria.
Vary dose if these occur.
In some susceptible patients it produces palpitation, visible tremor and internal agitation. If action is too severe, decrease dose or stop it.

EPINEPHRINE FOR INJECTION

Prescription No. 50 **Ampuls of Epinephrine Hydrochloride**

℞ Ampullae Epinephrinae Hydrochloridi, 1:1000, N. F.

Sig: 0.5 to 1 cc. to be injected as required.

The injection of epinephrine hydrochloride solution in asthmatic conditions is fully discussed on page 393.

Nasal sprays using Ephedrine are useful in hay fever and asthma.

Preparations previously published are:

Nebula Ephedrinae Comp. N. F. (N. J. F. No. 36)
Solution Ephedrine and Epinephrine (N. J. F. No. 42)
Emulsum Ephedrinae Comp. (N. J. F. No. 4)
Ephedrine Jelly N. F. (N. J. F. No. 1)

Ephedrine Sulfate or Hydrochloride av. dose, gr. ⅜—0.025 Gm.

AN ANTI-ASTHMATIC ELIXIR

Prescription No. 51 **Compound Elixir of Euphorbia**

℞

	Metric	*Apoth.*
Elix Euphorbiae Compositi, N. F. ...	120.0 cc.	f ℥ iv

Sig: f ℥ i, followed by a glass of water every three hours.

Note: Each teaspoonful contains approximately:

Flext. Euphorbia Pilulifera	m III	or 0.183 cc.
Flext. Lobelia	m 4/10	or 0.024 cc.
Sodii Bromidi	gr. 2 1/10	or 0.136 Gm.
Sodii Iodidi	gr. 2 1/10	or 0.136 Gm.
Spt. Glycerylis Trinitratis	m 6/10	or 0.036 cc.

Tr. Cardamom Comp.
Oil Peppermint
Glycerin
Alcohol
Distilled Water q.s.

FOR CONSTRICTION AND HYPERSECRETION

Prescription No. 52 **Tincture Belladonnae, U. S. P.**

℞

	Metric	*Apoth.*
Tincturae Belladonnae	30.0 cc.	f ℥ i

Sig: Ten drops in water every two or three hours until physiologic effect is obtained.

AN ANTI-ASTHMATIC COMBINATION

Prescription No. 53

℞

	Metric	*Apoth.*
Potassii Iodidi	2. Gm.	℥ ss
Tr. Belladonnae	4. cc.	f ℥ i
Spiritus Aetheris Co.	8. cc.	f ℥ ii
Elixir Aromatici, q.s.	60.0 cc.	f ℥ ii

M.

Sig. f ℥ i every two or three hours.

FOR RHINITIS

Prescription No. 54

℞

	Metric	*Apoth.*
Camphorae	0.195 Gm.	gr. iii
Ext. Belladonnae	0.097 Gm.	gr. iss
Quininae Sulfatis	0.780 Gm.	gr. xii

M. ft. caps. no. xii

Sig. One capsule every hour.

RECOGNITION OF MEDICAL LEADERS

The Medical Society of New Jersey has always been unusually free from factions, and fortunate in its leaders, many of whom inherited their characteristics from their fathers and grandfathers. The Annual Meeting of 1937 revealed unexpected sources of information regarding these leaders, whose example is still the unrecognized inspiration of medical leaders of today. The records of three of these leaders is set forth in the following articles. Other leaders will be memorialized as information regarding them becomes available.

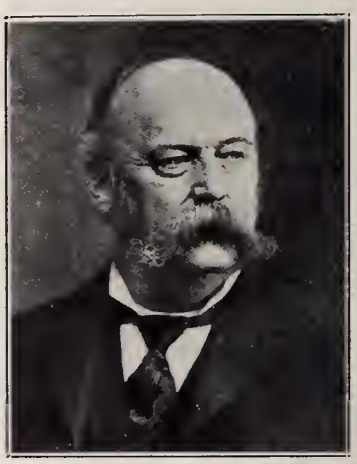
DR. OBADIAH H. SPROUL

Dr. Obadiah H. Sproul's record of attending fifty-three consecutive meetings of The Medical Society of New Jersey almost equals that of Dr. Joseph B. Harrison in attending sixty-one. (Jour., May 1937, pp. 342 and 354.)

An account of the life of Dr. Sproul is contained in The Journal of March 1925, pages 95 and 112. He was born in Middlesex County on May 29, 1844; and died February 13, 1925, aged eighty-one years. He was the son of the Rev. Samuel Sproul, to whom he owed his early education. He graduated from the University of Pennsylvania in 1866 and practiced in Stockton, Hunterdon County, for thirty-four years, and then in Flemington the rest of his life. He joined the Hunterdon County Medical Society on October 27, 1866. He was elected Secretary of his Society on April 18, 1871, and served continuously for fifty-four years until his death in 1925. This is probably a record that is unequalled.

The doctor also had a record, equally long, for attending the annual meetings of The Medical Society of New Jersey. Dr. Edward J. Ill recalls his presence, and described him as a quiet man who said that his only vacation and recreation consisted in attending the State Society meetings. While he does not seem to have made any speeches, or sought the limelight, yet his name frequently appears in the Transactions as making important motions that were to the point and acceptable to both factions in disputes. He enjoyed the entire confidence of his colleagues, and was made President of the State Society in 1894; and afterward served almost continuously as a Trustee until his death in 1925. Like Dr. English, he was deeply religious, and on one occasion he conducted the funeral services for a friend when the pastor was caught in a snowdrift and was unable to be present.

Dr. Sproul was instrumental in establishing the State Tuberculosis Sanatarium in Glen Gardner. A tablet to his memory was donated by the Hunterdon County Medical Society at its June 22nd, 1930, meeting, and reads as follows (Jour., Aug. 1930, p. 690):



OBADIAH H. SPROUL, M.D.
From The Journal, June 1916, p. 293

In Memory of
Obadiah Herbert Sproul, M.D.
1844—1925
Practicing physician in this county for sixty years
President of the New Jersey State Medical Society, 1894
Member of Board of Managers of this institution, 1902-1904
This tablet is erected by
Hunterdon County Medical Society

Two daughters of Dr. Sproul, Mrs. V. C. Hyde and Mrs. Eleanor Painter, still live in Flemington; and a grandson, Alan Painter, is now editor of the Hunterdon County Democrat in Flemington.

Dr. Sproul was a type of physician which has placed The Medical Society of New Jersey in the forefront among the medical organizations of the several states, for he was "a fine example of the 'Old Family Physician' so much admired and respected by all his associates". The memory of his service of fifty-four years as Secretary of his County Medical Society and as an attendant at the State meetings is an inspiration to every physician of New Jersey.

DR. DAVID C. ENGLISH

A memorial to Dr. David C. English was unveiled in the Presbyterian Church of New Brunswick on May 15, 1927 (Jour., July 1927, p. 443). The principal address was delivered by Dr. Wells P. Eagleton, whose eulogy led the Editor to prepare a brief description of the life and character of Dr. English on the tenth anniversary of the dedication of his memorial. It is fitting that Dr. English should be remembered in The Journal along with Dr. Sproul, for the two physicians were almost of the same age, and worked side by side in The Medical Society of New Jersey, both enjoying its highest honors and sharing its responsibilities, and exemplifying the same high qualities of leadership.

Dr. English was of the third generation of physicians. His grandfather, Dr. James English, was a native of Englishtown, which was named after the family, and was born June 15, 1757. He saw active service in the Army during the Revolution, and acquired a fortune in the practice of medicine largely because of his attractive manners, yet he did not belong to the State Medical Society. He died on December 30, 1816, and was buried in the Tennent Graveyard near Freehold.

Dr. James English left two sons, Dr. James English, Jr., who was born in 1793, and who continued his father's practice until he died of consumption in 1834.

A second son, Dr. David C. English, was born January 24, 1799. In 1821 he passed his medical examination before the censors of the Monmouth County Medical Society, as the result of which Dr. James Lee, President of The Medical Society of New Jersey, issued a license to him authorizing him to practice medicine anywhere in the State of New Jersey, in accordance with the Law of 1816. This happened six years before a similar license was issued to Dr. Elias J. Marsh, the first, by Dr. Isaac Pierson, President of the State Society. (P. 399.)

He moved to New Brunswick and became the leading druggist in the city, devoting more time to pharmacy than medicine. He died August 7, 1865, leaving a son, whom he named after himself.

Dr. David C. English, Jr., was born March 2, 1842, and died September 19, 1924. He practiced medicine in New Brunswick, but his outstanding work was in medical organization. Always striving to inspire his fellow doctors to practice better medicine, he had two objects in life,—his medical society and his church. For over half a century he was a pillar of the Presbyterian Church of New Brunswick; and on weekdays he exemplified the teachings of The Great Physician who went about doing good,—healing the sick, comforting the mourners, and binding up the wounds of the afflicted. Not only did he do these things himself, but he inspired others to do likewise.



DR. DAVID C. ENGLISH, JR.

An enlargement from a mass picture of those present at the State Society, June 27, 1893.

Dr. English was President of The Medical Society of New Jersey in 1897—three years after Dr. Sproul,—and afterward for many years he was Dr. Sproul's associate on the Board of Trustees. But his greatest work was that of editing The Journal, succeeding the first Editor, Dr. Richard Cole Newton, of Montclair, in July, 1906, and continuing until his death on September 19, 1924. In his editorship he was truly an "Elder", assuming its office when he was sixty-four years of age and continuing until his eighty-third year, rounding out a life devoted to the service of his fellow practitioners.

Dr. English was a man of small stature, but he always appeared in a frock coat, and with an enormous moustache which is shown in the enlargement of his portrait copied from a group photograph taken in 1893, at the Annual Meeting of the State Society in Asbury Park—the only known group photograph of the members attending an annual meeting.

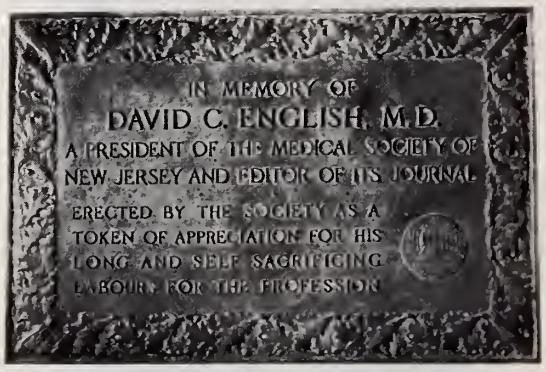
It was frequently said of Dr. English—probably truly—that attending a meeting of a

medical society was his idea of Paradise. The consistency of his attitude was evidenced by a tablet which The Medical Society of New Jersey placed on the wall of his Church, bearing the inscription:

"In memory of David C. English, M.D., a President of The Medical Society of New Jersey, and Editor of its Journal.

"Erected by the Society as a token of appreciation of his long and self-sacrificing labor for the profession."

In the words of Dr. Wells P. Eagleton, who gave the dedicatory address on the unveiling of the tablet (Jour., July 1927, p. 443):



Memorial tablet in the Presbyterian Church New Brunswick

"His life was a demonstration that man can be cultured, be learned, and still live by the power of faith. The Medical Society of New Jersey honors itself by here publicly testifying that self-sacrificing devotion to the interests of his fellows finds a resounding chord in the human heart."

CHURCH TABLETS TO PHYSICIANS

We wonder if the medical career of any other physician is recognized by a tablet in a house of worship?

It is true that on November 14, 1923, a tablet was placed in the St. John's Episcopal Church of Perth Amboy, N. J., to the memory of its pastor, the "Reverend" Robert McKean, A.M., M.D., during the week's celebration of the 225th anniversary of the founding of the church in 1698. This tablet was erected by The Medical Society of New Jersey because Dr. McKean was not only the pastor of the church, but was also a practicing physician and one of the Founders of The Medical Society on July 23, 1766, and its first President. (Journal, Dec. 1923, p. 444.)

It is worthy of note that another one of the fourteen founders of the State Society was also the pastor of a church.—Dr. Joseph Sackett, Jr., of Bergen County.

DR. ELIAS J. MARSH, First, Second, and Third

The inheritance of outstanding characteristics is illustrated by the three physicians bearing the name of Elias J. Marsh.—the grandfather, and the father both having been Presidents of The Medical Society of New Jersey, and the present Dr. Elias J. Marsh beginning his sixteenth year as Treasurer.

The immediate occasion for this recognition of the three generations of physicians bearing the same name was the preservation of the original document issued to the first Elias Joseph Marsh, of Perth Amboy, on July 16, 1827, certifying his qualifications to practice medicine. It was signed by three of the censors of the Middlesex County Society, when Dr. Isaac Pierson was President of The Medical Society of New Jersey.

Article 4 of the By-Laws of the State Society, adopted on May 9, 1820, reads:

"He (the President) shall grant a license with his signature and the seal of the Society, to all persons named in the certificates presented from the censors of the District Medical Societies of the State of New Jersey. He shall keep a register of the names of those whom he shall admit to practice physic and surgery in the State, and of the date when the license was granted, both of which he shall report to this Society at every stated meeting."

The records of licenses issued by the Presidents are printed in an appendix to the volume of minutes 1766-1858, that on Dr. Marsh being on page 725.

The first Elias J. Marsh was the son of Joseph, and grandson of Elias Marsh, who were shipbuilders in Perth Amboy. Dr. Marsh was born on January 7, 1803. He graduated from the College of Physicians and Surgeons of New York, and after receiving his license to practice medicine in New Jersey, he settled in Paterson where his son and grandson continued his practice. Dr. Marsh's name heads the list of the founders of the Passaic County Medical Society on January 14, 1844; and he

This will Certify, that we Charles Smith Jr.
Jacob Dunham and Wm Van Dumond —

— — —; Censors of the District Medical Society for the County of Middlesex — appointed by the Medical Society of New-Jersey, have this day carefully and impartially examined Elias Joseph Marsh of Perth Amboy — County of Middlesex — and State of New Jersey — : and being well satisfied with his attainments in the various branches of Medical and Surgical Science, and of his moral character; do hereby recommend him to the President of the Medical Society of New-Jersey, as a proper person, to receive a licence to practice PHYSIC and SURGERY throughout the State of New-Jersey.

In testimony whereof, we have hereunto subscribed our names and affixed our seals, at New Brunswick this sixteenth — — day of July — — — Anno Domini 1827 —

Chas. Smith
Jac. Dunham
Dumond

Certificate of proficiency in medical science issued to Dr. Elias J. Marsh First, by the Censors of the Middlesex County Medical Society on July 16, 1827. On its evidence, Dr. Marsh was granted a license to practice medicine by Dr. Isaac Pierson, President of The Medical Society of New Jersey.

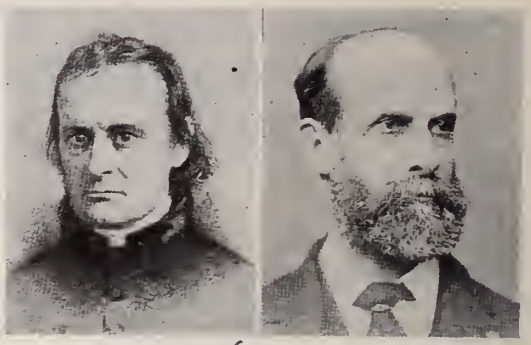
was one of the promotors of the first company engaged in silk manufacturing in Paterson. He was elected President of The Medical Society of New Jersey in 1850; but on October 29 of that year he died from the effects of overwork during a cholera epidemic.

Dr. Elias Joseph Marsh, 2nd, was born August 4, 1835, and graduated from the Col-

lege of Physicians and Surgeons in 1858. He served as Army Surgeon during the Civil War, and remained with the Army until 1870, when he entered into the practice of medicine in Paterson, and served as surgeon on the staff of the Paterson General Hospital. In 1890 he became Medical Director of the Mutual Life Insurance Company of New York, and was elected President of The Medical Society of New Jersey in 1891. He died August 3, 1908, aged 73 years. Of him it was said in his obituary:—

"As surely as there is a Better World, so surely is he there, helping weakness, guiding strength, and passing the laurels to others."

Eliash J. Marsh, 3rd, graduated in 1900 from the same school as his father and grandfather, and is now the Treasurer and a Trustee of The Medical Society of New Jersey.



DR. ELIAS J. MARSH I DR. ELIAS J. MARSH II

REGISTRATION OF PHYSICIANS BY COUNTIES AT THE ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY APRIL 27-29, 1937

The following table shows the number of members of each County Medical Society who registered at the 1937 Annual Meeting; and also the percentage of registrants in the number of members printed on the Official List of 1937:

County	No. of Members on Official List	No. Registered at the Annual Meeting, 1937	Per Cent Registered
Atlantic	115	95.	82.
Bergen	222	25.	11.2
Burlington	55	22.	40.
Camden	174	47.	27.
Cape May	23	16.	70.
Cumberland	55	21.	38.
Essex	788	113.	14.33
Gloucester	39	18.	46.
Hudson	395	55.	14.2
Hunterdon	21	2.	9.
Mercer	201	22.	22.
Middlesex	113	30.	26.
Monmouth	122	55.	45.
Morris	88	19.	23.
Ocean	25	12.	48.
Passaic	273	11.3	11.3
Salem	20	35.	35.
Somerset	55	17.6	32.
Sussex	20	2.	10.
Union	291	52.	18.
Warren	30	8.	26.
Total 1937	3125	696.	22.3
1936	2840	582.	20.5
1935	2871	465.	16.2
1934	2750	549.	20.0

ANNUAL MEETING DATES OF COUNTY SOCIETIES

Instead of all the annual meetings of the county medical societies being held in the Fall, four-fifths of the counties now hold their meetings in the late Spring. Suggestions for the change originated in the Conference of County Secretaries and Reporters on November 7th, 1934, and was described in The Journal of November, 1934, page 647. The change was discussed editorially in The Journals of December, 1934, page 673; October, 1935, page 567; and February, 1936, page 66. Progress in securing a change of dates is shown in the following table:

Counties	Month of Annual Meeting 1934	1937
Atlantic	Nov.	May
Bergen	Jan.	May
Burlington	Nov.	Same
Camden	Oct.	May
Cape May	Oct.	April
Cumberland	Oct.	April
Essex	Oct.	May
Gloucester	Nov.	May
Hudson	Oct.	May
Hunterdon	Oct.	April
Mercer	Dec.	Same
Middlesex	Dec.	Same
Monmouth	Dec.	April
Morris	Sept.	June
Ocean	Nov.	Same
Passaic	Oct.	May
Salem	Oct.	April
Somerset	Dec.	June
Sussex	Sept.	May
Union	Oct.	Same
Warren	Oct.	*June

*Election in October, take office in June

An analysis of the table shows that the times of taking office have been changed from Fall to Spring in 71 per cent of the counties; the counties making the change have 77 per cent of the membership of the State.

The object of the change was to make the administrative periods of the county societies to coincide with those of the State Society, thereby promoting the efficiency among all groups that are concerned with organized action. The important consideration is not the date on which the officers are elected, but that on which they take office.

CONFERENCE ON VENEREAL DISEASE CONTROL

A State-wide conference was held on May 18th, 1937, in New Brunswick, on the subject of Venereal Disease Control. The program was arranged principally from the viewpoint of lay health and welfare organizations, and emphasized the part which they should take in control measures.

The principal participating organizations were the New Jersey Health and Sanitary Association, the New Jersey Health Officers Association, the New Jersey State Department of Health, and The Medical Society of New Jersey. The part taken by the Medical Society was largely advisory in the preparation of the program. Representatives of the Society were present as observers, and as unofficial advisers of the representatives of the lay organizations whom they met informally.

The attendance was:

At the moving picture	1300
At the afternoon meeting	500
At the evening session	700

The spirit of the conference was one of deference to the medical men. The practical points that were discussed were principally on the subject of how the social organizations could assist in carrying out the projects of The Medical Society of New Jersey, and the State Department of Health.

DEMONSTRATION OF VENEREAL DISEASE CLINIC

The most practical part of the program were the demonstrations of how a physician handles a venereal disease problem in his private practice. These were under the direction of Dr. C Byron Blaisdell, of Long Branch, and of Dr. R. L. McKiernan, of New Brunswick, who was in charge of local arrangements.

1. The demonstration for physicians was in the Middlesex General Hospital. A room was arranged as a physician's office. Fifteen syphilitic patients presenting different diagnostic and therapeutic problems were the basis of discussion. The diagnostic problems were discussed, and then the patients were treated by the latest methods just as a physician would treat them in his office. The various steps in the present coöperation with local and State health authorities were integrated. Although this was the first step in the educational program of the State Society, the fifty-four physicians attending were pleased and felt well repaid for their time in attending.

2. The demonstration for health officers and social workers was held in a large hotel room fitted up with the simple means for giving injections of arsenicals to syphilitic patients. The equipment consisted of the following pieces of furniture and apparatus:

1. A desk for the doctor.
2. A table on which were the syringes and liquids used in giving the injections.
3. A darkfield microscope in which living spirochetes were shown.
4. Two nurses.

Dr. Blaisdell conducted the demonstration of a clinic, which consisted in showing the several steps through which a patient passed on his first visit. The doctor first talked to the patient and prescribed the treatment which he was to receive.

The patient then seated himself at the administration table with his sleeves rolled up, ready to receive the injection;—but no injection was given, the object being merely to show the simplicity of the procedure. The point was emphasized that the procedure which the patient undergoes is almost exactly of the same nature as that which a patient suffering from any other condition would receive, and would not indicate to others the nature of his disease.

While the demonstration was that of a free clinic especially for syphilitic patients, yet the examination and treatment itself did not involve any embarrassment to the patient, or any disclosure of the nature of his complaint.

The principal feature of the demonstration was a running comment on the part taken by the nurse in securing the attendance of the patient. The point was emphasized that the patients in the clinic established an attitude of comraderie among themselves and toward the nurse and doctor, which was the same as that

which is shown, for example, by a group of patients receiving a series of electrical treatments for arthritis.

To practitioners of medicine a most valuable feature of the demonstration was the running comment on the part taken by the nurses in their contacts with the patients. The clinic absolutely avoided any reference to the moral aspects of the disease. When once the patient grasped the idea that he was being treated as a scientific problem, he showed the same cooperation as that of a patient with tuberculosis or arthritis.

The nurses related experiences in tracing the sources of the infection,—and even here the patients were as coöperative as those having tuberculosis, and were willing to disclose the probable source of their infection.

Today the attitude of the average syphilitic patient is about the same as that of the tuberculosis patient two decades ago when the disease was considered a disgrace to be hidden from his associates. Since the word syphilis has been popularized, and the nature of the disease has become popularly known, the patients are accepting treatment with the same willingness that tuberculosis patients show.

In some respects the outlook for treating syphilitic patients with success is more encouraging than the outlook for the tuberculosis patient. This point is that the essential part of the treatment of syphilis consists in the administration of a drug at intervals of approximately a week; and in the meantime the patient may continue at his work and go among other people without disclosing any evident signs of his affliction or the treatment which he is undergoing.

This peculiarity of the disease is in contrast with that in tuberculosis, in which the patient is pale and thin, often has a cough, and is evidently weakened physically so that his affliction is evident to his associates; and, finally, drugs are of only minor importance.

THE GENERAL PROGRAM OF THE CONFERENCE

The program began at ten o'clock with a motion picture on "Damaged Lives". This was designed to show the unpleasant and serious side of syphilis and its effects on the patient and his family. It was a *popular* rather than a *medical* picture, and had a value as an appeal in order to arouse the people to a sense of their personal obligation to support an anti-syphilitic campaign.

At noon there was a dinner at which the large hall, seating 250, was filled to overflowing. After dinner addresses were given by Dr. J. Lynn Mahaffey, Director of the State Department of Health, and R. A. Vonderlehr, Assistant Surgeon General, U. S. Public Health Service.

The afternoon was devoted to group discussions and demonstrations. The demonstration of the Monmouth County Clinic (which is described above) was held in a small room which was crowded with about forty persons, mostly nurses and men engaged in clinic work.

Other groups discussed problems such as "Official Problems and Responsibilities", "Preventive Medical Social Service", "The Training School for Follow-up Work of the University of Pennsylvania Medical School", and "Syphilis and the Mother and Child".

In the evening there was an exhibit of charts, diagrams, and pictures, held in the gymnasium of Rutgers University. Printed literature was distributed and demonstrators explained the salient features of the preventive and curative phase of the anti-syphilitic movement.

An evening session was held in the gymnasium, at which the principal speakers were Professor C. E. A. Winslow of Yale Medical School on "The Romance of Syphilis"; and Dr. Walter Clark, Director of Social Hygiene of the New York City Department of Health, on "Our Immediate Objectives".

SUMMARY

1. The Conference was of unusual interest and practical value. Family doctors learned the nature of the service which they can render and were encouraged to take up the work.

2. Nurses and social workers were made aware of the major importance of purely medical work, and the futility of hygienic advice which is necessary in tuberculosis.

3. Members of welfare organizations were shown that the essential part which they are to take is that of providing the financial and physical means by which physicians can give the drug treatments which alone are curative in the disease.

4. Practicing physicians learned the need of the medical services which they alone can give, and on which alone cures depend in most cases of syphilis.

5. The conference was well designed and conducted to bring about an understanding of the part which each group must take.—doctors, health officers, nurses, welfare officials, and the people generally.

6. Above all, the conference showed what practical good can be accomplished when all groups of workers plan a program centering around the medical aspects of the subject of syphilis.

REPORT ON LEGISLATION

The Legislature adjourned on May 28th at 9:00 p. m. The members plan to return for special legislation regarding relief on June 28th, and to have one meeting in October.

This legislative year has been a trying one, although we have been successful in holding in committee A-233, to regulate the practice of naturopathy; A-235, to regulate the practice of chiropractic; and A-236, to extend reciprocity under the osteopathic act.

The bill to place a practicing plumber, A-34, on the State Board of Health was kept in committee; as was A-530, which provides for establishment of a Bureau of Narcotic Control; and A-534, which prescribes eye and ear examinations for public school pupils. That bill was good in purpose, but poor in the ways and means recommended.

A-525, to take proprietary and patent medicines out of the exclusive hands of pharmacists and sell them through groceries and elsewhere, was kept in committee, as was A-526, which was withdrawn by Mr. DeVoe on the protest of the Medical Society. This bill was to make special consideration possible for the State Board of Medical Examiners, a condition which the State Board of Medical Examiners themselves did not want.

A-425, to provide and limit the amount of free pneumonia serum for indigents, passed the House unanimously; but though it was on the board for final passage in the Senate, it did not come to a vote due to adjournment.

S-139, to provide $2500 to aid the families of typhoid carriers, passed both houses, and has been delivered to the Governor.

S-54 passed the Senate and died in the Assembly. This bill provided cancer treatment hospitals through the Freeholders, in Essex County especially.

A-3, to prohibit or regulate the sale of fireworks, was passed.

The Medical Society had no bills of its own this year, but was instrumental in preventing the passage of bills that were opposed by the profession.

A-242 provides for custodial care and treatment, by Health Departments, of deaf children under six. This bill affects a small fraction of one per cent of the children under six. Our committee thought it was poorly worded, but not of any particular significance to the profession.

Altogether the season in the Legislature was satisfactory from the standpoint of the Medical Society.

BOARD OF MEDICAL EXAMINERS

The following is a report of the Board's activities in enforcing the Medical Practice Act since our last report, which included the activities up to and including February 26, 1936 (Journal, May, 1936, page 310):

In March, 1936, George Van Dyke, a naturopath of Trenton paid the penalty for practicing medicine without a license.

March 16th, 1936, David J. Latta, a licensed osteopath of Pleasantville, who was prescribing internal medication, pleaded guilty before the Judge of the Court of Common Pleas of Atlantic County to a charge of practicing medicine without a license.

March 16th, 1936, Joseph Miller, a licensed chiropractor of Newark, who was exceeding his license, paid a penalty for practicing medicine without a license.

March 18th, 1936, the Board revoked the license to practice medicine and surgery of James M. Hackett of Leonia for conviction of the crime of criminal abortion.

March 27th, 1936, William A. Bird of Long Branch, who gave massage and manipulative treatments, paid a penalty for practicing medicine without a license.

March 30th, 1936, Earl E. Kailey, an unlicensed chiropractor of Trenton, pleaded guilty before the Judge of the Trenton District Court to a charge of practicing medicine without a license.

In April, 1936, Russell Leitch of Camden, who held himself out as a foot specialist, paid the penalty for practicing medicine without a license.

April 23rd, 1936, Marie E. Mount, a nurse, of Plainfield, who was giving electro-therapeutic treatments and high colonic irrigations without a physician's order, pleaded guilty before the Judge of the Elizabeth District Court to a charge of practicing medicine without a license.

May 12th, 1936, Aram Hachadoorian of West New York, an unlicensed chiropractor, pleaded guilty before the Judge of the First District Court of Jersey City to a charge of practicing medicine without a license.

May 20th, 1936, the Board revoked the li-

cense to practice medicine and surgery of James W. Blackwood of Camden for conviction of the crime of criminal abortion.

June 10th, 1936, Harry C. Knisell, a grocer of Camden, who was prescribing drugs for internal use, paid the penalty for practicing medicine without a license.

June 15th, 1936, Charles Baxter of Paterson, whose license to practice medicine and surgery was revoked on September 19th, 1934, pleaded guilty before the Judge of the Paterson District Court to a charge of practicing medicine without a license. On the same day his wife, Emma Baxter, who was giving electric treatments under his direction and also under the direction of another licensed physician, pleaded guilty to a charge of practicing medicine without a license.

In June, 1936, Louis J. Lukach, a druggist of Milltown, paid a penalty for practicing medicine without a license.

July 8th, 1936, the Judge of the Camden District Court found Susanna Lichtwark of Camden guilty of practicing medicine without a license.

July 14th, 1936, John P. Field, an unlicensed chiropractor of Newark, pleaded guilty before the Judge of the First District Court of Newark to a second charge of practicing medicine without a license and paid the penalty.

September 2nd, 1936, Sarah M. Cardell, a physiotherapist, who had an office at the Stockton Hotel, Sea Girt, was found guilty by the Judge of the Asbury Park District Court of practicing medicine without a license. She refused to pay the penalty and was committed to jail for fifteen days.

September 4th, 1936, the Judge of the Ocean County Court of Common Pleas found Linwood L. Righter, M.D., a licensed physician of Pennsylvania who was practicing in Seaside Park during the summer of 1935, guilty of practicing without a license. The defendant paid the penalty.

September 28th, 1936, the Judge of the Court of Common Pleas of Atlantic City found Horace T. Davies, an unlicensed chiropractor of Atlantic City, guilty of practicing medicine without a license. The defendant refused to pay the penalty and was committed to jail for thirty days.

September 30th, 1936, Pearle Schaeffer, a representative of the Natural Health Products Company of New York City, who had a concession on the Boardwalk in Ocean Grove, pleaded guilty before the Judge of the Asbury Park District Court to a charge of practicing medicine without a license and paid the penalty.

September 30th, 1936, Bergen Moran, who operated a blood pressure machine on the Boardwalk near the North End Hotel in Ocean Grove, was found guilty by the Judge of the Asbury Park District Court of practicing medicine without a license. He refused to pay the penalty and was committed to jail for twenty days.

October 7th, 1936, the Judge of the Asbury Park District Court found Francis Le Pompadour, a naturopath, guilty of practicing medicine without a license. The defendant paid the penalty.

October 10th, 1936, Henry J. Gommoll, a physiotherapist of Newark, paid a penalty for practicing medicine without a license.

October 12th, 1936, Marie Matchinsky, a licensed osteopath of Pennsylvania, who was practicing in Ocean Gate during the summer, paid the penalty for practicing medicine without a license.

October 24th, 1936, Patrick Blake, a physiotherapist, with an office in the New Monmouth Hotel at Spring Lake, paid a penalty for practicing medicine without a license.

November 13th, 1936, the Judge of the Common Pleas Court of Atlantic County found Walter E. Cleveland, a licensed chiropractor, guilty of practicing medicine without a license. He was acting as Director of the Gravitonic Life Ray Discovery Office at 802 Pacific Avenue, Atlantic City. The defendant refused to pay the penalty and was committed to jail for thirty days. On the same day David Martin, who gave electric treatments under the direction of Walter E. Cleveland and Catherine B. Flemming, who was connected with the same office, were also found guilty of practicing medicine without a license. Martin refused to pay the penalty and was committed to jail for thirty days and Catherine B. Flemming paid the penalty.

December 2nd, 1936, Alfred Becker, a masseur of Asbury Park, was found guilty by the Judge of the Asbury Park District Court of practicing medicine without a license. Becker was found guilty of a similar violation by the judge of the Monmouth County Court of Common Pleas on September 24th, 1931.

January 14th, 1937, Isabel B. Turner, M.D., of Englewood, pleaded guilty before the Judge of the Englewood District Court to a charge of practicing medicine without a license and paid the penalty.

January 18th, 1937, the Judge of the Common Pleas Court of Atlantic County found Max Plager, an operator of a blood pressure machine, not guilty of practicing medicine. The Attorney General has applied to the Supreme Court for a writ of certiorari.

January 20th, 1937, the Judge of the Asbury Park District Court found May Lee Clonts, who was examining patients and prescribing "Walk Easy Foot Cushions" to relieve foot ailments, guilty of practicing medicine without a license. The defendant paid the penalty.

January 27th, 1937, the licenses to practice osteopathy and chiropractic of George E. Harley of Newark were revoked by the Board for the practice of criminal abortion.

February 15th, 1937, Richard Miller, a naturopath of Newark, pleaded guilty before the Judge of the First District Court of Newark to a charge of practicing medicine without a license.

February 16th, 1937, Stanley J. Bayorek, an unlicensed chiropractor of Irvington, pleaded guilty before the Judge of the First District Court of Newark to a charge of practicing medicine without a license.

James J. McGuire, *Secretary.*

BOOK REVIEWS

The Practice of Medicine. By Jonathan Campbell Meakins, M.D., LL. D., Professor of Medicine and Director of the Department of Medicine, McGill University; etc. Pp. 1343; 505 illustrations (35 in color). The C. V. Mosby Co., St. Louis. Price $10.00.

On opening this excellent new textbook of medicine, one is struck by the absence of the familiar initial chapter on the infectious diseases, for the arrangement is primarily upon an anatomical rather than an etiological basis. Discussions of the symptomatology and the physiology as related to the disorders open the sections on diseases of the lungs, the circulatory system, the liver and the bile passages, metabolism, and the nervous system; rheumatic fever and diabetis mellitus are especially well treated; for the latter the author recommends the high carbohydrate diet.

The book is very well illustrated. The general tone is conservative and fair, and it is worth while to quote one sentence from the discussion of the surgical treatment of tuberculosis, "Here again careful selection of the case has given the best results and as the surgeon must undertake the operation, it is only fair that he should be consulted as soon as there is any suggestion that it might be advisable in the future"; this advice for early consultation is again given in the consideration of empyema. There has been some carelessness in proofreading with errors such as "mycrotic" for mycotic occurring. This work may well be recommended for its general worth.

G. N. J. Sommer, Jr.

Operative Surgery. By J. Shelton Horsley, M.D., LL.D., F.A.C.S., Attending Surgeon, St. Elizabeth's Hospital, Richmond, Va., and Isaac Bigger, M.D., Professor of Surgery, Medical College of Virginia, etc. Vol. 2; pp. 1387, 1259 illustrations. Fourth edition. St. Louis; C. V. Mosby Co.

The fourth edition of this work contains much that recommends it to the practicing surgeon. The style and the excellent composition make reading easy. Each chapter is accompanied by a bibliography that is not oppressively long. In choosing the procedures to be described, the authors have limited themselves largely to the ones used in their own practice and that have proven themselves to be suitable. It should be pointed out that this is not a textbook of anatomy; a knowledge of this subject is required of the reader.

Many points of special interest could be mentioned after reading the two volumes. Among them are the views of Horsley on the mechanism of surgical drainage; the preference of Bigger for the use of rectal ether anaesthesia for a number of conditions; the recommended use of catgut for gastric and colonic anastomosis; and the preference for a modification of the Billroth 1 operation for resection of the stomach. The authors are definitely opposed to the use of metal plates in the treatment of fractures. Several pages are devoted to the care of lacerations of the scalp, which could be read by those in charge of accident wards with considerable profit.

It is interesting to note the description and recommendation of the operation of the late Dr. Frank V. Cantwell, of Trenton, for the correction of epispadias.

The two volumes may be recommended both for reference and for complete and thorough reading.

G. N. J. S., Jr.

Social Component in Medical Care; A Study of One Hundred Cases from the Presbyterian Hospital in the City of New York. By Janet Thornton, Director, Social Service Department. In collaboration with Marjorie Strauss Knauth, Assistant Physician, Department of Medicine. Octavo. Cloth; price $3.00; 411 pages. N. Y. Columbia University Press, 1937.

"The Social Component in Medical Care" brings forcibly to the mind of the physician that the best results in treatment can be obtained only through the fullest understanding of all the conditions and circumstances surrounding a patient. Failure to understand the fears, anxieties, or conflicts of a patient interferes with proper adjustment and recovery. Since physicians usually do not have the time to obtain a complete picture of the patient, this book clearly shows the value of, and need for, the special social service worker. One hundred case records are presented, which are concise, yet sufficiently complete, to indicate clearly the value of social service from a diagnostic as well as from a therapeutic standpoint.

Julius Levy.

A Preface to Nervous Disease. Stanley Cobb, Psychiatrist in Chief to the Massachusetts General Hospital. First Edition. William Wood and Company, 1936, Baltimore. (173 pages.)

In this small volume, Cobb compresses brief accounts of the basic anatomy, pathology, and physiology of the nervous system. The problems discussed are made clear but somewhat oversimplified by a series of verbal and pictorial schematizations, in which the pathology of each condition is presented concurrently with the anatomy and physiology. Psychiatry receives but scant attention, for in the entire volume, only six pages in a section designated "psychopathology" are devoted to normal or morbid psychology. In neurology, the approach is more phylogenetic than clinical, so that the understanding of the motor, sensory, and autonomic nervous systems is given on the basis of the building up of developmental levels. The treatment of the clinical problems themselves is irregularly patchy. Thus the myopathies receive seven pages, while the important and common problem of multiple sclerosis is disposed of in a single page. The usually obscure and neglected subject of neuropathology is very vividly and readably presented in a short but compact chapter. It is difficult to know for whom the book is best adapted. It is too non-clinical for the general practitioner, too unsystematized for the medical student, and too abbreviated for the neurologist. On the other hand, academic students of psychology will find the volume both interesting and instructive. It is also an admirable fireside volume for physicians outside of the field of neurology who wish to feel somewhat more at home with the basic concepts of neuropsychiatry, or who find relaxation in the extracurricular reading of material which is not too far removed fom the problems of their profession.

Henry A. Davidson,
Newark.

Research in Dementia Precox. Nolan D. Lewis, Professor of Neurology at Columbia University. 320 pages. National Committee for Mental Hygiene. New York, 1936. (Price: $1.50.)

This is the report of the research project on dementia precox, undertaken by the National Committee for Mental Hygiene, with a grant given by the Supreme Council, 33° Northern Masonic Jurisdiction (U. S. A.). While primarily the volume is an index to the bibliography of the subject, it makes affirmative contributions on the problem of giving direction to research in this field. In Particular, Lewis deplores the inadequate use of the biologic-expermental approach, although he is not unmindful of the difficulties in the path of such a technic. Two thousand papers, books, and monographs on schizophrenia are indexed and classified. Following a review and critical analysis of past research trends, the editor presents chapters on clinical features, etiologic aspects, pathology and physiology, diagnosis and treatment. In each chapter the lines of research and the significant conclusions are pointed out. The bulk of the book, however, is made up of the classified bibliographic index which lists papers and books on the subject of the chapter, published between 1920 and 1935.

Discussing future possibilities, Lewis points out the stumbling blocks in the way of fruitful research, including therein the tendency of psychiatrists to shun tentative working hypotheses, the nosologic confusion, the difficulty of handling human material, and the absence of experimental lower animals.

More specifically he recommends the paying of more attention, along psychologic lines especially, to the problem of deterioration states and deteriorated personalities; the further development of complete and extensive histologic, anatomic and pathologic studies of the brains and other organs of victims of schizophrenia; the integration of the work of psycho-analysts, sociologists, psychologists, and biochemists; the reëvaluation of clinical material in the light of entire person-environment complexes rather than from the viewpoint of piecemeal analyses of classified snatches of data; and in general a centralized and coördinated working pattern of research and clinical facilities.

Taken by themselves, the introductory discussions of each subdivision of the material constitute a stimulating monograph on the subject. The bibliographic index will be an indispensable guide to scholars and research workers in this field.

Henry A. Davidson,
Newark.

LIST OF PHYSICIANS DYING IN NEW JERSEY IN APRIL, 1937

Supplied by the State Department of Health

Name	Age	Date Death	Place of Death	Residence	Cause of Death
Winfield S. DeVausney	55	April 6	Newark	Newark	Struck by auto.
Ernest A. Farrington	56	April 5	Haddonfield	Same	Cerebral hemorrhage.
Harry L. Hall	64	April 22	Orange	Same	Cerebral hemorrhage.
Harry J. Harp	55	April 6	Sussex Borough	Same	Arterio sclerosis
Robert L. Mason	39	April 12	Trenton	Same	Cardiac decompensation.
Walter Reynolds	72	April 18	Atlantic City	Same	Coronary occlusion.
Henry B. Rue	81	April 2	Hoboken	Same	Myocarditis
Isaac Surnamer	64	April 23	Paterson	Same	Arterio sclerosis.
Lars T. Wendelboe	70	April 23	Newark	Same	Cancer of sigmoid.

CONTACTS AND COMMENTS

A newspaper reporter makes use of chance contacts, and discovers valuable items in unexpected sources. The inspiration for the three biographical notes contained in this Journal (p. 396) came from incidental remarks made to the Editor, who is always ready to "talk shop" and to follow up clews.

To discover and report items of historical interest is a project which fits perfectly into the scope of the Woman's Auxiliary.

The American Association of the History of Medicine met in Haddon Hall, Atlantic City, on May 3, 1937, and was attended by Dr. Leslie E. Myatt, of Bridgeton, and Dr. Royce Paddock, of Newark. Its Secretary and Treasurer is Dr. E. J. G. Beardsley, 1919 Spruce Street, Philadelphia, Pa. The Association is affiliated with the International Association of the History of Medicine, and the subjects of its program are those of the broader aspects of medical science and art.

The Medical Society of New Jersey has as its own historical field the discovery and preservation of local records and biographies, but research into any branch of medical history broadens one's interest in all others.

There has been a vast improvement in the news items sent by county society reporters during the last year. Every month The Journal carries reports of the responses of county societies to proposals made by the State Society.

Of still greater importance is the increasing number of projects undertaken by county societies on their own initiative.

Best of all is the willingness of county societies to report their unusual activities, as Gloucester County did in the May issue when it described the dinner given to two of its members on their half century of medical practice.

The Journal is always ready to coöperate with county societies in giving publicity to local events which are inspiring models and precedents for other societies to follow.

Months roll by in quick succession, and news items pour into the editorial office at embarrassingly late dates.

It is the purpose of the Publication Committee that The Journal shall be mailed on or before the tenth of each month; and the Editor is frequently asked "What is the deadline for receiving items for publication?" The reply is, "There is always time for inserting an important item, even up to the last minute." It is the custom of the Editor to spend the last day of preparing The Journal at the printery, so that important items may be incorporated in The Journal. But this usually requires the elimination of items already made up for publication,—a process which is unfair to the more prompt contributors.

Don't wait until the last minute before sending your items. Don't even wait until a stenographer is at hand. Send the news in any form you wish,—the Editor will put it into shape for publication. The typesetter can read the handwriting of the Editor; and besides the Editor expects to be at the printery to correct the slight errors which are inevitable in last-minute reporting.

There will be a lull in reportable medical activities during the summer months; but that does not mean that nothing of importance will happen. On the contrary, during June and July the new officers of the State and county societies are more active than at almost any other season, for they are busily engaged in making up the personnel of their committees, and planning the projects to be put into full force during the early Autumn.

The Journal during the months of Summer will carry an increased proportion of scientific articles in order to compensate for the absence of news of meetings and conferences. But all indication point to a greatly increased amount of activity in the Fall when the new committees come into full production.

Contacts of physicians with lay health organizations are becoming more and more important. For example, the conference on venereal disease control, which is reported on page 401, was of great significance. It revealed a willingness and desire on the part of the lay leaders to profit by the advice and direction of the officers and committeemen of the medical societies. A goodly number of physicians attended the conference, and were accorded a hearty welcome. The friendly contacts of prac-

ticing physicians with the lay leaders is rapidly bringing about a coöperation which was unknown until very recent years.

The influence of medical societies is essential in inspiring and guiding the lay workers in their activities; and on the other hand, the medical societies are dependent on the response of health workers, both voluntarily and official, in achieving their objectives.

The Journal needs more articles on Mental Hygiene,—not articles on the technicalities of mental derangements, but those dealing with incipient mental states, which if untreated, lead to insanity and crime. Examples of understandable articles are those dealing with abnormal behavior of children,—the basic conditions which are found; how to make a test of the mental age of an unruly child; the underlying conditions in epilepsy; and the detection of the causes of backwardness of school children. All these conditions are brought to the attention of the Family Doctor as the first authority to be consulted; and in the absence of special instruction, the Family Doctor is compelled to rely on his "common sense" in dealing with the patients. Physicians will apply the principles of diagnosing and treating these incipient conditions if they are presented in the form of clinical reports of cases, and of simple explanations of their pathology.

The Committee on Mental Hygiene is giving serious attention to the relations of Family Doctors to this field of medical practice.

The Handbook of Preventive Procedures is receiving a great amount of quiet recognition and approbation, and a minimum amount of criticisms. However, a serious error crept into the directions for breast feeding on page 28, where the statement is made *"At each feeding* give one and a half ounces of milk for each pound of the child's weight." This should read *"During each day"*.

Again, there is an error in the statement, "This diet will supply one and a half *grains* of protein per pound of body weight".

The word *grains* should read *grams*.

Our attention has been called to the accessory report of abnormal congenital conditions that is to be filed with the regular birth certificate, when such conditions are found.

Another important condition is that of recording the births of adults who were born before the law of reporting every birth was universally enforced.

An article on both of these conditions is now being prepared under the auspices of the State Department of Health. The practical value of the articles is indicated by the fact that several physicians have inquired how they may have their own births officially recorded.

During the early months of Summer, several county societies will hold "outing" meetings, with pleasure as their objective. These outings are of equal importance with the scientific sessions, for they promote that good fellowship and morale which are essential in the medical profession.

Some serious-minded physicians like to take their pleasures vicariously, and fully enjoy the antics of their more sporting brethren. Reports of the outings are proper items for The Journal, and will be reported for their own intrinsic value. Snapshots of members at play will always be popular.

The major editorial project during the month of June will be the preparation of the Transactions of the Annual Meeting for publication. The stenographic reports of the last Annual Meeting are more accurate, and logical, and complete than ever before, because of several factors:

1. The members took advantage of their opportunities to clarify their views by consultation with the Reference Committees, several of whom held midnight sessions.
2. The stenotypist was unusually efficient, and did not hesitate to request the Chairman to re-state uncertain points, and repeat names which were not clearly understood.
3. The officers and the committeemen held the discussions within logical limits; and the speakers coöperated with them in reframing their motions to conform to the procedures set forth in the Constitution and By-Laws.

In editing the minutes, special attention will be given to cross-references to reports published in the April Journal; and to actions taken by previous annual meetings, and by the official bodies of the Society. The value of the cross-references becomes clearly apparent when a member or officer tries to trace the passage of a resolution through several sessions, to the final action which is taken.

The Transactions will be published as a supplement to the July Journal. Copies of the galley proofs will be submitted to the officers; and on their response will largely depend the promptness with which the Transactions are printed and distributed to every member.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

June			July	
8 Bergen	17 Morris		20 Warren	27 Hunterdon
8 Cumberland	23 Monmouth			
9 Mercer	Camden (Outing			
10 Somerset	Meeting)			
16 Middlesex				

BERGEN COUNTY

LeRoy W. Black, M.D., Reporter

The annual meeting of the *Bergen County Medical Society* was held at Bergen Pines Hospital on Tuesday, May 11th. It was in the form of a Spring Festival wherein sixty to seventy members took part in sports of various sorts. The winners were awarded prizes. After a tour through the new building the meeting was called to order by Dr. J. H. Irwin, our president.

In view of the Convention of the American Medical Association from June 7th to 11th, it was decided to postpone the next meeting of the Society to a time agreed upon by the officers.

NEW MEMBERS

The following were elected to membership:

To Junior:

Dr. Samuel Weinstock, Teaneck
Dr. James M. Jones, Teaneck
Dr. Walter F. Modrys, Hudson Heights

To Associate:

Dr. C. V. Burt, Hackensack
Dr. A. M. Hambright, Ramsey

ELECTION OF OFFICERS

The following were elected to office for the year 1937-38:

OFFICERS

President ..... Charles Littwin
Vice-President ..... Chester A. King
Treasurer ..... L. A. Markley
Secretary ..... G. M. Knowles
Reporter ..... LeRoy Black

Delegates	*Alternates*
Walter J. Farr	C. de S. Pallen
J. H. Irwin	J. Teal
Samuel Alexander	Joseph Van Dyke
LeRoy Black	J. M. Coppoletta

1935-36-37 (elected in 1935)

H. B. Wilson	Vincent Farmer
F. S. Hallett	H. H. Vandersluis
G. W. Finke	J. B. Edwards
G. M. Levitas	S. B. Reich
Charles Littwin	R. K. Tether
David Corn	E. H. Deisberg
C. A. King	D. B. Hull
C. N. Dezer	L. A. Markley
E. P. Essertier	F. G. Dilger

For years 1937-38 Dr. S. B. Reich alternate for Dr. G. M. Levitas.

1936-37-38

J. R. Morrow	M. Sarla
A. Liva	E. T. Seymour
E. N. Huff	L. A. Hitzemann
W. Vroom	V. A. Blenkle
G. M. Knowles	L. Burnham

Nominating Committee Representative:
A. Liva
S. Alexander

SCIENTIFIC

Dr. Joseph M. Morrow, Superintendent of Bergen Pines, spoke upon the work at Bergen Pines and introduced the speakers.

Dr. Oddino Bernardini spoke upon the "Early Diagnosis of Pulmonary Tuberculosis".

Dr. R. M. Anderson showed moving pictures of Bergen Pines, the members of its professional staff, and pictures demonstrating the "Technique of Thoracoplasty".

The meeting was adjourned for supper which was kindly supplied by the hospital.

BURLINGTON COUNTY

Parry M. Scott, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club on May 13th, 1937. This meeting was a social one, with the members of the Woman's Auxiliary as guests of the society. The attendance was large, practically all of the members of the Auxiliary being present. In the absence of President Small, the meeting was called to order by Vice-President Fahrenbruch at 9:50 p. m.

The Secretary announced a Conference on Venereal Disease Control to be held in New Brunswick on May 18th, 1937.

Dr. George T. Tracy asked to be relieved of his duties as a member of the Committee on Constitution and By-Laws, and requested that President Small appoint his successor.

Vice-President Fahrenbruch introduced Mrs. Dean

H. LeFavor, President of the Woman's Auxiliary, who responded with the following bit of original poetry:

"For this treat for several years we've had to wait,
So we put up a squawk and you too the bait;
It takes none of the joy from this pleasant occasion
To have had to beg for this kind invitation.
It's true that we've felt it our very just due,
To come as a group, and commune with you,
And to see just what bright and what shining lights
Make you keep us at home on these Thursday nights.
We see that you're fed, and we run your homes,
And we tell your lies on the telephones—
So to give a night out is like answering a prayer,
For we doctors' wives seldom get anywhere.
So accept our deep thanks for this evening so pleasant,
Which came as our tenth anniversary present;
And we've loved being out with our husbands so dear,
And we'll come back again if you'll ask us next year."

Vice-President Fahrenbruch then turned the meeting over to Dr. Howard C. Curtis, Chairman of the Committee on Program, who introduced the entertainer of the evening, Mr. Gus Bohn. Mr. Bohn baffled and amused us for some time with his mind reading, sleight of hand, and card tricks, and was very cordially received.

Following some group singing and the serving of a buffet supper, the society adjourned to meet in Moorestown in September.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The annual meeting of the *Camden County Medical Society* was held May 4th, 1937, in the Camden City Dispensary Building, Dr. B. F. Buzby presiding.

NEW MEMBER

Dr. Barroway was received into the society.

CHILD WELFARE WORK

Dr. B. Wroblewski was approved by the society to do Child Welfare Work under the social security grant.

ANNUAL OUTING

Dr. Shipman reported that the committee in charge of the Annual Outing had selected June 3rd, 1937, and the place Tavistock Country Club. There will be tennis, golf, and a free dinner for the society members.

ELECTION

The following list of officers were elected:

President, J. Lynn Mahaffey, M.D.
Vice-President, H. Wesley Jack, M.D.
Secretary, George B. German, M.D.
Treasurer, E. C. Shull, M.D.
Reporter, Harold D. Barnshaw, M.D.
Historian, Helen F. Schrack, M.D.
Censor, B. F. Buzby, M.D.
Trustee, Alex. MacAlister, M.D.

On the motion of Dr. E. B. Rogers, the society recommend to the Camden County Board of Freeholders that a detention ward in one of the county institutions be provided for the observation of mentally ill patients; and that a committee from this society be appointed to present these resolutions to the Freeholders. Before there has not been any place in Camden County for observation. At times the county jails have been used or the patient has been committed to the insane asylum.

CRIPPLED CHILDREN

Dr. B. F. Buzby gave a most interesting talk concerning the development and work of the Crippled Children's Commission. It was inspiring to hear of the vast amount of work this committee had performed.

The incoming officers were read the oath of office, and Dr. J. Lynn Mahaffey, the new President, took the chair.

Dr. Gamon retired from the secretarial post after six years of faithful service. Dr. B. F. Buzby expressed his appreciation of the retiring Secretary's ability, and the society gave him a rising vote of thanks.

CAPE MAY COUNTY

Warren D. Robbins, M.D., Reporter

A meeting of the *Cape May County Medical Society* was held on Thursday, May 20th, 1937, at the Ocean City Golf Club, with the President, Dr. John B. Townsend, presiding.

The following members were present: Drs. Townsend, Corson, Bernheisel, Hornstine, Giddings, Friedland, Monson, Crowe, Way, Tomlin, Hughes, and Darby. Guests included Drs. V. Earl Johnson, W. P. Chalfonte, W. P. Conway, Samuel Barbash, Alfred Wesney, W. J. Carrington, and William E. Darnall, of Atlantic City; Robert Grier, of Pleasantville; J. J. Schroeder, of Trenton; Herbert Wilson, of Bridgeton; Rostin White and Mr. Herbert Addiscott, of Somers Point; Lieutenant John Lowe, of Cape May; and Mr. John Friel, of Ocean City.

NEW MEMBER

Dr. Samuel Hughes, of Cape May, was elected to membership.

SCIENTIFIC

The scientific session consisted of an address by Dr. John A. Brooke, Professor of Orthopedics at Hahnemann Medical College, Philadelphia. The subject was "Fracture of the Neck of the Femur", which was presented in a masterful manner by Dr. Brooke and ably discussed by Dr. V. Earl Johnson, of Atlantic City.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

The 122nd Annual Meetng of the *Essex County Medical Society* was held on Thursday, May 13th, 1937, at 8:45 p.m. in the Academy of Medicine, Newark. President Edgar A. Ill presided.

This was the first annual meeting to be held by this County Society in May instead of in October since the procedure was changed to make the term of service more uniform for the officers and committeemen of the State Society and the component county societies.

The election of Councilors was also significant because it was the first election of Councilors as specific representatives of the five districts into which the county has been divided.

ELECTION OF OFFICERS

The following officers, representatives, and new members of the Essex County Medical Society were elected:

Officers (one year):

President, Dr. H. Roy Van Ness, Newark
First Vice-President, Dr. David A. Kraker, Newark
Second Vice-President, Dr. Walter B. Mount, Montclair
Secretary, Dr. Frank W. Pinneo, Newark
Treasurer, Dr. Robert H. Rogers, Newark
Reporter, Dr. Earl LeRoy Wood, Newark

Councilors:

For One Year—
District No. 2, Dr. John T. English, Irvington
District No. 3, Dr. Irving L. Farr, Montclair
For Two Years—
District No. 4, Dr. John D. Moore, Bloomfield
District No. 5, Dr. W. H. A. Warner, East Orange

Nominating Committee of State Medical Society (one year):

Dr. Alfred Stahl, Newark, Member
Dr. A. Charles Zehnder, Newark, Alternate

Trustees of Medical-Dental Service Bureau (three years):

Dr. Edgar A. Ill, Newark
Dr. James H. Lowrey, Newark
Dr. Walter B. Mount, Montclair

Delegates to State Society (three years, to 1940):

Delegates—
Dr. Arthur W. Bingham, East Orange
Dr. John H. Bradshaw, Orange
Dr. Francis N. Carbone, Newark
Dr. Harry N. Comando, Newark
Dr. John F. Condon, Newark
Dr. Hugh F. Cook, Newark
Dr. R. Y. Hubbard, Irvington
Dr. H. B. Kessler, Newark
Dr. Manfred Kraemer, Newark
Dr. August J. Mitchell, Newark
Dr. George S. Reitter, East Orange
Dr. H. H. Satchwell, Newark
Dr. Earl H. Snavely, Newark
Dr. Edward W. Sprague, Newark
Dr. Theodore Teimer, Newark

Alternates—
Dr. James S. Allen, East Orange
Dr. Mary E. Broadnax, Newark
Dr. Elbert A. Curtis, Newark
Dr. Joseph I. Echikson, Newark
Dr. Linn Emerson, Orange
Dr. Edward A. Flynn, Belleville
Dr. Albert S. Harden, Newark
Dr. William H. Huber, Newark
Dr. Herbert M. Ill, Newark
Dr. Henry H. Kessler, Newark
Dr. John D. Moore, Bloomfield
Dr. Royal A. Schaaf, Newark
Dr. Ellis L. Smith, Belleville
Dr. Florence Voorhees, Newark
Dr. M. Weinstein, Irvington

Alternate (one year till 1938)—
Dr. S. A. Muta, West Orange

Members of the Society:
Regular—
Rhys Jones Aaron E. Parsonnet

Associate—
Anthony R. D'Addario

The Tellers for the election received ballots from 7:30 p. m. till 10 p. m. They were the following: Harold A. Murray, M.D., Chairman; S. W. Ebenfeld, M.D.; M. F. Hubach, M.D.; Robert H. Rogers, M.D.; E. L. Smith, M.D.; Arthur H. Richardson, M.D.; Mayer Nimaroff, M.D.; Eugene P. Schaeffer, M.D.

COMMITTEE ON NECROLOGY

The Committee on Necrology—consisting of the following: William Petry, M.D., Chairman; J. H. Bradshaw, M.D.; H. S. Connamacher, M.D.; J. Sobin, M.D.—had published and distributed an "In Memoriam" pamphlet containing individual obituaries of these departed members: Winfred Eugene Baldwin, Frank C. Bunn, Lawrence M. Demarest, Winfield Scott Devausney, George B. Emory, Herman Louis Fuerstman, John F. Hagerty, Samuel B. Whitman Leyenberger, Charles P. Opdyke, Fred Albro Pringle, William Milton Rathgeber, Henry V. S. Stout, Henry Middleton Woolman, Lars Thomas Wendelboe, Reuben Zimmerman. During the reading of these names by President Edgar A. Ill, the society stood in silence.

TREASURER'S REPORT

Treasurer Robert H. Rogers presented his report, which was accepted with an enthusiastic demonstration signifying the gratitude of the membership for his long and faithful services as Treasurer. The Auditing Committee consisted of Drs. Richard N. Connolly and George Blackburne.

Treasurer Rogers announced for the Finance Committee that the dues for each member of Essex County would amount to $22 for 1938. This total consists of:

$15 for the State Society
6 for the County Society
1 for the Relief Fund

$22 Total

PRESIDENT ILL'S REPORT

The retiring President, Edgar A. Ill, made his presidential address in the form of a report on his term of office as follows:

"It has been a great pleasure since last October to serve the Essex County Medical Society as its President for the balance of the year 1936 and the beginning of 1937 to its present annual meeting. It is especially pleasant for me to look back over the very active and satisfactory support which I have received from the members. It has indeed been a very pleasant year.

"*The Council meetings* have been very active and well attended, and the little monthly parties at these Council meetings have been a relaxation and a happy time. You members who have not attended the Council meetings are unaware of Past Presidents. From my own experience, I hope there will never be a change from giving the Past Presidents the opportunity which they have had to the present time to present their views and to carry on with the active work of the County Society. To my way of thinking this is very important.

"Drs. Hawkes, Wherry, Bingham, Barkhorn, Lowrey, Areson, Sprague, Condon, and Zehnder have attended every meeting this year and I would like hereby to especially thank them for this fine attendance. This coöperation of the Council and Past Presidents has made the work very easy and very pleasant for me.

"Under the chairmanship of Dr. E. P. Cardwell, the *Economics Committee* has accomplished much valuable work. As a result of its work, a physicians' collection agency known as *The Professional Agency* has been established, and is in operation; and is a real forward step. This is the first time that doctors have had a collection agency under their own control. This branch of our economic security project has made satisfactory progress. It has entailed a great deal of work.

"This committee has also put in motion the Central Admitting Bureau, which will, along with the Medical-Dental Service Bureau, eventually solve many of our problems. This latter Bureau continues to make progress, and has been just out of the red now for several months.

"The *Savings Life Pension Plan* was also completed by this committee and is in operation, and many men have availed themselves of its very fine opportunity to buy this kind of insurance, which is easy to handle by monthly payments and is very valuable.

"Changes were also made during the past year as a result of this committee's work as regard to case lifting and moral and professional misconduct of physicians and also as to giving improper court testimony and the publishing by any member of newspaper articles concerning the ability or abilities or professional actions of physicians. This is fully described in Dr. Cardwell's report. The work of this committee has done a great deal to protect doctors from political control of medicine.

"The *Hospital Committee* under the chairmanship of Dr. E. W. Sprague has likewise been very active. Much work was done by this committee. The meetings were well attended by all the members and much progress has been made toward establishing a hospital for the care of the chronic indigent. Dr. Sprague's report, which you have heard, is very complete.

"You have heard the report of the *Public Health Committee* under the chairmanship of Dr. Edward C. Klein, and a very interesting and valuable meeting was held under the auspices of this committee on the subject of syphilis. Drs. Sellers, Kasselman, and Craster spoke at this meeting. Doctors will be obliged to be interested in this subject, as the matter has been made public through the U. S. Department of Health, and unless we take a prominent part, this work will get out of our hands.

"I do not wish to take up your time with long details of the work of these committees as you have already heard them from the committees' reports.

"I wish especially to speak of the work of the Committee *'to Study Representation on the Council'*. Dr. John F. Condon was Chairman of this committee. The committee has been unusually active, and with the action which you have taken tonight we hope that there will be a united Essex County Medical Society, augmented by support from the suburban districts. Some changes in places of meetings of the County Society may be necessary. Whatever is done along this line is most valuable and important.

"The *Cancer Committee*, under the chairmanship of Dr. Henry B. Orton, has also done a great deal of work. Under the active leadership of Dr. Orton, a definite step has been taken to establish in Essex County, under the control of the Board of Freeholders, a cancer hospital for indigent patients. Dr. Orton has been active in trying to establish this hospital for the past two or three years, and I wish especially to comment on the final result of his activity.

"I am sure that you will realize the great importance of a hospital of this kind which will take care of cancer patients who must be designated as incurable and indigent individuals.

"I wish now to report that, under the active cooperation of the Council of the Essex County Medical Society, the Hon. Governor Harold G. Hoffman has again reappointed Dr. H. H. Satchwell a member of the New Jersey State Board of Medical Examiners. It is important that we have a member from Essex County on this board.

"The work of the *Publication Committee*, which has charge of the monthly Bulletin under the chairmanship of Dr. J. H. Bradshaw, is most important. A great deal of time and work and energy is spent in preparing a monthly bulletin, and I would recommend that this bulletin be enlarged and that more space be sold for ethical advertising so that the bulletin will not be a cost, but rather an asset, to the County Society.

"During the past year the *office of the Essex County Medical Society* has been established in the same office as the Medical-Dental Service Bureau. The usual difficulties in establishing such an office have been overcome, and now the office work is coordinated with the work of the *Medical-Dental Service Bureau* under the direction of Mr. Edwin Parker. It is my hope that this action will iron out some of the difficulties. Many meetings of the

committees have been held in the office of the Essex County Medical Society. I believe this very valuable because at least the members can see the operation and physical layout of the Medical-Dental Service Bureau.

"During the year, I have felt that the work of the Essex County Medical Society was sometimes lagging. However, in making a casual survey I find that much progress has been made. As Dr. Eagleton, who is still a very active member and, in fact, a leader, explained to me, 'The pendulum swings both ways'; and although the progress upward is not rapid, something is accomplished each year, and I hope that we will be able to look back over this year and feel that we have contributed something to the progress and welfare of the Essex County Medical Society, and the welfare of the doctors. There is much difference of opinion at the various meetings held during the year, both of the Council and the various committees, but usually a happy path is found.

"I wish again to thank the members of the Essex County Medical Society for their active support of the work which the Council and the various committees have carried on. It is only the amount of support we have with the work which makes good progress possible."

INSTALLATION OF PRESIDENT VAN NESS

The new President, H. Roy Van Ness, was escorted to the rostrum and introduced to the society by Dr. Ill. Dr. Van Ness was presented with a beautiful gavel as a symbol of his office, and of the affectionate regard with which he is held. He accepted the installation and expressed his appreciation of the tokens with appropriate remarks.

The chief business of the meeting was acceptance of the reports of the various committees showing their activities during the year.

REPORT OF HOSPITAL COMMITTEE BY DR. SPRAGUE

In the report of the Hospital Committee and subcommittees, Dr. E. W. Sprague said:

In order that you may quickly grasp the work of this committee, the following topics have been thoroughly studied:

1. Advising all hospitals to check up all staff members as to their membership in the Essex County Medical Society.

2. In what manner can the high cost of nursing care to the patient be reduced without lowering efficiency? This problem was passed on to the State Nursing Advisory Committee.

3. In the matter of professional liability of internes, we recommended that the State Society urge the insurance companies to include coverage for internes.

4. We recommend that internes should sign no death certificate without the approval of the attending physician.

5. The minimum standards of the American College of Surgeons were considered.

6. The matter of hospital care of the chronic ill in Essex County was seriously studied; and you have already considered and acted upon the recommendations of this committee. This problem before the Hospital Committee did not include cancer cases because that subject had been covered by the Cancer Control Committee.

7. The question of individual physician's eligibility for full or limited privileges in the hospital was studied thoroughly; and you have heard, considered, and acted upon the recommendations of the Hospital Committee.

8. After reviewing the *Hospital Insurance Plan* and hearing the viewpoint of the roentgenologists, the committee's recommendation was that x-rays should not be included in the Hospital Insurance Plan.

9. The inadequacy of *Social Service* investigations in practically all the hospitals has been stressed; and we ask the coöperation of the lay boards with the medical staff in eliminating people who should not receive free service.

10. Again we ask for adequate representation of medical men on lay boards of hospitals.

11. Lastly, we recommended that survey be made of this county of the admission of patients to hospitals and clinics, with the idea of finding out just what abuse of medcal charity is being carried on and how it may be remedied. This was recommended to be made by the Welfare Federation of each community.

SUB-COMMITTEE ON HOSPITALIZATION OF THE CHRONICALLY ILL, BY DR. SPRAGUE

The Report of the Sub-Committee on Hospitalization of the Chronically Ill deserves detailed considcration and is as follows:

Your Sub-committee on Hospitalization of the Chronically Ill Indigents of Essex County held three meetings, and after reviewing the subject from all angles presents the following criteria or essential fundamental points as being the minimum that the medical profession of this county should advocate and insist upon in regard to the indigent chronically ill:

1. Experience and survey have definitely established the need of a County Hospital for Chronic Cases.

2. That this problem is the responsibility of the Board of Freeholders.

3. That admission to this hospital should be limited to indigents; i. e., those cases unable to pay for necessary proper hospitalization.

4. That adequate Social Service investigation should insure that only indigents be admitted to this institution.

5. That upon the establishment of a Central Admitting Bureau, we deem it advisable that this agency be used.

6. That the institution should be known as *County Hospital for Chronic Cases and Convalescents.*

7. A survey by your sub-committee shows need of county for hospital beds for chronic indigents approximately as follows:

Chronic arthritis	150
Adult cripples	100
Chronic cardiacs 1300—20 per cent needing hospitalization	250
Hemiplegics, neurological, nephritis, etc.	150
Total	650

For practical purposes we recommend that capacity be not over 400 in the first unit constructed.

It will be noted that your committee did not consider the indigent cancer case in this report, as this problem is being handled by another committee of the County Society; and for obvious reasons tuberculosis and mental cases were not considered.

8. That if the Board of Freeholders decide to proceed with the erection of such a hospital, work should not be started nor should plans be approved by the Board of Freeholders without consultation with and the approval of a committee of physicians appointed by the County Medical Society. We particularly emphasize the need of consultation between the Board of Freeholders and the medical profession regarding (1) size and type of building, (2) location, (3) bed capacity and (4) type case to be admitted.

Raymond J. Mullin, M.D., *Chairman*
Frederic A. Alling, M.D.
Manfred Kraemer, M.D.
Ellis M. Smith, M.D.
F. E. Hubbard, M.D.

SUB-COMMITTEE ON COURTESY PRIVILEGES IN HOSPITALS, BY DR. SPRAGUE

The report of the Sub-Committee to Study Courtesy Privileges in the Hospitals was submitted to the Council a few weeks ago. The Council referred the report back to the Hospital Committee for further study. At our last meeting this report has again been approved, and we refer it to the Council for consideration. The recommendations are:

1. That a representative Council, or Credential or Eligibility Committee, be appointed by each hospital to control the eligibility of all candidates as to their privileges.

2. That this information may be interchanged from one hospital committee to another upon request.

3. Before a candidate is eligible to perform major surgery without supervision, he shall have practiced a minimum of five years after a one-year internship, or four years after a two-year internship. Certain special preparation or ability may be accepted by the individual Hospital Committee in lieu of a portion of above time. The mere act of practicing five years does not constitute the privilege to do major surgery, but is only a minimum requirement; and in addition to this the individual Hospital Comittee must vote on the candidate's ability, fitness, and judgment for same.

4. It is recommended that in the field of obstetrics the rules laid down by the Maternal Welfare be followed.

5. A suggested list of what constitutes minor and major procedures should be developed in the five fields as follows:

(a) General surgery
(b) Genito-urinary work
(c) Ear, nose and throat
(d) Eye
(e) Orthopedics

The matter of the relationships of the Radiologists and the Hospital Insurance Plan came before us for further discussion. A Joint Committee of the Radiological Society of New Jersey, the Medical Society of New Jersey, the New Jersey Hospital Association, and the Hospital Service Plan of New Jersey has been arranged to discuss the problem:

JOINT COMMITTE REPORT
By Dr. Sprague

At the meeting of the Hospital Committee, April 19, 1937, the Committee authorized the chairman of the committee to present for the consideration of the Council, the report which would be developed at the Joint Committee Meeting, as stated below:

Report of the Joint Committee of the Radiological Society of New Jersey, the Medical Society of New Jersey, the New Jersey Hospital Association, and the Hospital Service Plan of New Jersey, appointed to consider the propriety of the inclusion of the services of Radiologists under the Hospital Service Plan.

Tis Committee met Tuesday, April 20th, at the Presbyterian Hospital. Those present were: Dr. Tidabach, Dr. Reitter, Dr. Sprague, Dr. Marquis, Rev. Martin and Mr. Colman. The following resolution of the Radiological Society of New Jersey was received and upon motion, ordered placed in the archives of the committee:

"Whereas the practice of Radiology is recognized as a distinct branch of the Practice of Medicine by the Radiological Society of New Jersey; the Radiological Society of North America; The American College of Radiology; and the American Medical Association, and

Whereas, Hospital Service Plans offer hospitalization for a certain number of days for a stated fee, and

Whereas, these contracts state they do not include the services of Physicians, and

Whereas, certain contracts do include the item of Roentgen Rays which also includes the services of the physician who directs the production of the roentgenograms, interprets them, and administers the necessary rays in the treatment of disease, and

Whereas the working of such contracts is not inclusive in regard to all physicians,

THEREFORE be it resolved by the Radiological Society of New Jersey that the Boards of Trustees of Hospital Service Plans be petitioned and their attention directed to the above facts; and be it further

RESOLVED that the Radiological Society of New Jersey recommend that the item of X-Rays be excluded from the services rendered in future contracts of the Hospital Service Plans."

After careful consideration of the resolution and lengthy discussion by the members present, the following recommendations were adopted:

1. The services of Radiologists should not be included as a hospital service.

2. As soon as possible the services of Radiologists should be excluded from all hospital service plans.

3. The present varied relationships between hospitals and Radiologists, and the fact that the patient now pays the hospital for the services of a Radiologist, all tend to confuse the public as to his professional status. A joint committee of the bodies represented on this committee should study this problem, and recommend steps whereby the present confusion in the public mind concerning the professional status of the Radiologist may be eliminated and his proper professional status as a consultant of the treating physician made clear.

4. The representatives of the four bodies represented in this committee should present this report to the body which they represent, explain the reasoning which led to the adoption of these recommendations, and suggest the endorsement of this report and its recommendations by these bodies.

Respectfully submitted,

The Radiological Society of New Jersey,
By J. D. Tidaback, M.D.
The Medical Society of New Jersey,
By E. W. Sprague, M.D.
The New Jersey Hospital Association,
By Rev. John G. Martin
The Hospital Service Plan of New Jersey,
By J. D. Colman

PUBLIC HEALTH COMMITTEE

For the *Public Health Committee,* Dr. E. C. Klein, Jr., said that his committee had limited its activities to a stimulation of interest in the venereal disease control campaign.

PUBLIC RELATIONS COMMITTEE

For the *Public Relations Committee,* Dr. H. Roy Van Ness reported as follows:

The three major objectives of the Committee have been:

1. Contacting lay groups
2. Memberships on lay boards
3. The formation of a Speakers' Bureau

A satisfactory Speakers' Bureau has been established, and speakers have been furnished to various groups.

A group has been formed, the members of which are to sit with lay groups in an advisory capacity, when requested.

A course in public speaking has been considered. We hope that our successors on this committee will be able to start such a course in the Fall.

Your committee feels that it should stress the necessity for group consciousness and group action. We are glad to have the public know of the achievements of the medical profession as a group, but no individual is to be exploited by having his name appear, for, after all is done and said, men doing the same line of work know the same things; there are no secrets, patents, or magic wands in medicine.

Questionnaires.—Our members are requested not to answer questionnaires received from various sources and with various motives; but to let the County Society investigate and answer for them as a group; otherwise our organization will fail, and the day will be postponed when organized medicine will be able to say to malefactors, "You cannot continue to do what you are doing, because it does not produce the greatest good for the greatest number."

Public Relations.—The medical profession to date, as a group, has failed to sell itself to the public. Each individual respects his own doctor, but is not so enthusiastic about the profession as a whole. Your committee hopes it has at least made a start in selling the *profession as a whole* to the public; and believes that future Public Relations Committees must of necessity proceed with this aim uppermost.

Your committee believes the *Woman's Auxiliary* to be efficient in the carrying out of a successful Public Relations program and recommends, that its continued coöperation be sought.

LUNG COMMISSION

For the Lung Commission, Dr. R. H. Dieffenbach reported:

During the year, this Committee had several meetings, discussing mainly organization, minimal requirements for chest clinics, and the group tuberculin testing.

There were meetings at which a representative of the school authorities, the Radiologists, and the Essex County Tuberculosis League were present. We also had a representative at an organization meeting of the Oranges and Maplewood to make suggestions on the Tuberculin Testing of school children; and these municipalities, we are glad to report, are making excellent progress.

There were also four scientific sessions which I regret to state were not well attended, in spite of the fact that the subjects presented were of general interest and the lecturers were men of authority in their fields.

For the future, the commission plans to continue drawing up plans for organization, minimal requirements for chest clinics, and program of medical lectures. To obtain a better attendance at the lectures, it is the concensus of opinion that wider publicity should be given. In this we hope for your coöperation and assistance.

MATERNAL WELFARE COMMISSION

For the Maternal Welfare Commission a very significant report was read by Dr. Eugene W. Erler as follows:

"Since October 1936, your Maternal Welfare Commission has held four meetings in alternate months; two of these were business meetings of the commission for the transaction of routine business, and two were open meetings to which members of Obstetrical staffs of various hospitals or men known to be interested in Obstetrics were invited.

Of the two open meetings, the first was held at Orange Memorial Hospital under the able guidance of Drs. Bingham and Potter, and was very well attended by doctors from many parts of the county. The program consisted of presentation of cases, a paper on the effect of estrogenic substance

on menstruation, and moving pictures by Dr. Potter on the use of Piper forceps in breech deliveries and forceps rotation in occipital posterior positions. It was felt by the members of the commission that such good material should not be wasted on so small an audience; and might better be presented through the Academy of Medicine to a larger group; so that we have held no further clinical meetings.

As always in the past, our prime motive has been to improve the practice of obstetrics in our community, and to lower our self-advertised high maternal mortality rate. As our statistics include the deaths of all pregnant women, regardless of cause, we feel that maternal deaths from medical or surgical diseases, and from abortions whether induced or not, should not be included in these statistics. To obtain correct classification, we requested that no death certificate in obstetrical cases should be signed by an interne without full knowledge and consent of the visiting obstetrician. Also, we requested that in obstetrical cases the following questions be added to the death certificates:

1. Was the condition causing death present before pregnancy?
2. Was pregnancy a factor in causing death?
3. What was the month of gestation?
4. If a baby was born, give date or birth.
5. In case of abortion, gave date.

These additions have been suggested to the Bureau of Child Hygiene, but apparently there has been no response to date.

Our hospital committee gets full statistics yearly from all the hospitals of the county, and the results have been carefully tabulated. A full report of these figures will be published soon.

Let me remind you of the improvement in *Maternal Mortality* in the past ten years in our County and State, for our County figures have a large influence on those of the State. We hope that some of the improvement shown may be due to the efforts and investigations of your commission.

Year	*State*	*Essex County*
1925	6.2 deaths	6.8 deaths per 1000
1927	6.1 deaths	6.9 deaths
in both years, county rate higher that state		
1931	5.9 deaths	4.8 deaths
1936	3.7 deaths	3.5 deaths

Both established a new low record and our County has been steadily lower that the State.

But let me add a needed note of our present weakness. The deaths among whites and colored have been separated, and it has been found that among the white population, the deaths have been 2.7 per 1000; while among the colored of the county, the rate has been 10.5; the highest in the state. There is need of great improvement in the obstetrical practice among the colored people of the county.

COMMITTEE ON ILLEGAL PRACTITIONERS

The Report of the Committee on Illegal Practitioners, Dr. J. A. Clarken, Chairman, showed 29 cases investigated of which 11 are still in the process of completion.

MEMBERSHIP COMMITTEE

The Membership Committee, Dr. C. F. Rathgeber, Chairman, reported that:

We have at present 824 regular paid-up members, and 85 paid up Associate members making a total of 909 members who have paid dues to date. Assuming that the three candidates to be voted upon tonight are elected our total membership at the close of this meeting will be 912.

WELFARE COMMITTEE

The Welfare Committee report was read by its Chairman, Dr. W. H. Areson:

The Welfare Committee met on May 4th, 1937, to consider bills of interest to the medical profession now pending in the legislature.

Senate No. 54—introduced by our own Senator Dr. Clee.

This Bill was introduced with the purpose of answering the Essex County Medical Society's request to the Board of Freeholders for an institution where the proper diagnosis and the treatment of cancer and its allied diseases could be carried out.

This Bill contains the statement that "cancer is hereby construed to come within the meaning of contagious or infectious diseases".

With this viewpoint, this Committee cannot agree, and our recommendation is that this reference to cancer as a contagious or infectious disease be deleted.

Assembly No. 499—This is to repeal an act to provide for liens in favor of hospitals and other charitable institutions, furnishing care, etc., of persons injured in an accident.

This Bill in no way affects our Physicians Lien Law, but it does state "Certain unscrupulous physicians attached to hospitals file claims upon every accident case, demanding outrageous sums for their fees".

This Committee takes exception to this unjust, unwarranted statement about the medical profession, and requests this part of the bill be deleted.

Assembly No. 420—This is an act to provide assistance to needy pneumonia victims, and makes an appropriation of $25,000 for this work.

This money is to be expended by the State Department of Health in the purchase and distribution of anti-pneumococcus serum to any licensed physician of this State upon his written request that his patient is afflicted with pneumonia and is financially unable to purchase the necessary serum.

This Bill has our hearty endorsement.

Assembly No. 526—This Bill removes standards set up some years ago governing the action of the State Board of Medical Examiners in determining the qualifications of those who wish to license in this State by reciprocity.

This Bill would permit the Board of Medical Examiners to use its own discretion.

Because this discretionary power of our State Board of Medical Examiners may be used for political or favoritism needs, we are strongly opposed to its passage.

We wish to emphasize the fact that medical men must assume and maintain an active interest in

politics, particularly where health measures are at stake.

PHYSICAL THERAPY COMMITTEE

For the Physical Therapy Committee, Dr. J. I. Fort, Chairman, said that:

The problems for next year will be to consider the formation of a *Society of Physical Therapists* for study of the problems of physical medicine, and the question of the formation of an association of physical therapy technicians. This latter is of note as there is an appeal from the technicians to the State Society to consider the question of a *State Registry* for such technicians.

COMMITTEE ON ACUTE POLIOMYELITIS

For the Committee to Study Acute Poliomyelitis, Dr. E. L. Smith, Chairman, reported:

The lack of incidence of Poliomyelitis during the past year allowed no comparison with the attempted actively immunized group in this County. Research likewise produced no new facts. Therefore, we would reiterate our previous recommendations:

1. That all biological or chemical prophylaxis be considered in the experimental stage.

2. That all suspicious illnesses be promptly reported to the Health Departments with particular attention as to the paralytic or non-paralytic type.

CANCER STUDY COMMITTEE

For the Cancer Study Committee, Dr. H. B. Orton, Chairman, read a report, a portion of which follows:

Subsequent correspondence with Supervisor Ernest A. Reed concerning a Radiological Department at the Isolation Hospital resulted in an invitation from the Board of Freeholders to meet with it on October 22nd, 1936, Dr. Areson, Dr. Satchwell, and the Chairman conferred with this body and laid before the Freeholders the need for such an institute. The result of this conference was that a committee of the Board of Freeholders was to meet with the Advisory Board of the Essex County Isolation Hospital and several members of the Cancer Committee. The meeting was held at the Isolation Hospital, December 10th, 1936, and this project was again discussed in detail, taking up the cost of equipment, maintenance, etc. At this meeting the Advisory Board of the Essex County Isolation Hospital reversed its original recommendation, i. e., "that a building be set aside for this purpose." Their reason for so doing was the increased number of communicable diseases which they had during the past year. It was also brought out at this meeting that the Freeholders could build or rent a building as they considered advisable.

January 25th, 1937, the Cancer Control Committee held a meeting and passed the following resolution: "We favor the establishment of a separate cancer hospital for the indigent of Essex County, and strongly urge the Board of Freeholders to erect a new building for this purpose. If, in the judgment of the Board of Freeholders, this is not feasible at this time, we recommend the immediate rental of the Hospital for Women and Children, and to properly equip the same for the diagnosis, treatment, and care, with the maintenance thereof, for the indigent cancer patients of Essex County."

This resolution was presented the same evening to the Council of this Society.

On February 11th, 1937, Dr. Bernard Pierre Widmann, Director of the Radiological Division of the Philadelphia General Hospital was the speaker before this Society on the subject: "The Management and Treatment of Malignant Disease and the Value of Tumor Clinics". At the invitation of the President of this Society, members of the Board of Freeholders were invited to this meeting.

On March 15th, 1937, the Cancer Control Committee held a meeting and decided that, concerning the resolution of this committee as of January 25th, the Committee has been acquainted with the outline of the Curie Institute; and that this Committee goes on record as favoring the principles laid down by the Curie Institute, and we disapprove of Senate Bill No. 54.

MEDICAL DEFENSE COMMITTEE

For the Medical Defense Committee, Dr. Irving L. Farr said:

This is a new committee, formed at a suggestion of the Chairman of the State Committee on Medical Defense, in order that each county society might more closely deal with *Physicians' Liability Insurance problem*, through a better acquaintance with the individual members, with the hope, that through the lessening of mal-practice suits, eventually, the members may receive cheaper rates for protection. Therefore, this Committee stands ready to coöperate fully with the State Society's Defense Committee; and also, with the Insurance Company in the investigation of any case.

This Committee asks authority to call before it any member of the Society, who is believed to have caused a mal-practice suit to be brought against him, either inadvertently, or willfully; and anyone being sued, has the privilege of calling upon the Committee.

The Committee trusts, that when a case arises, the insurance company will expedite investigation and early settlement, if possible, in order that less opportunity shall be given for publicity, thus lessening the power of suggestion to prospective litigants.

The Committee recommends to the membership of the County Society:

1. That each and every member *keep full and accurate records* of every case, and employ consultants freely.

2. That the services of The Professional Agency be used for collections, since, often times, the effort to collect slow accounts becomes the basis for a mal-practice suit.

3. That every member of the Society resolve to speak in no derogatory manner of a brother physician, under any circumstances, relative to his work or personality.

MEDICAL-DENTAL SERVICE BUREAU

The Medical-Dental Service Bureau of Essex County reported as follows (the report being read by Dr. H. H. Satchwell):

The report of the Medical-Dental Service Bureau is brief and cheerful.

During the eighteen months of the Bureau's existence it has written business having a total value of $182,280. Of this amount, $86,279 has been for physicians, $10,949 for dentists, and $85,052 for hospitals.

Actual disbursements to professional members during that period have been $89,225. Hospitals received $41,100 of this, dentists $6,659, and physicians $41,466. I would like to repeat the amount that the Bureau has paid to physicians—$41,466.

The Bureau Staff has taken nearly 3000 interviews.

Since the beginning of this year the Medical-Dental Service Bureau has been self-supporting. In other words its income has been slightly in excess of its operating expenses for the past four months.

There are a number of so-called Bureaus operating in various parts of the country; but to the best of my knowledge ours is the first and the only one that has ben able to stand on its own feet and pay its own way. Some of you probably thought this day would never come. Actually, it has been here since the first of the year. There has been an untold amount of hard work and sacrifice behind this success of the Bureau, which very few of you will ever know. It is sufficient to say that the success is due both to the loyal support of the professional men who found that the organization is a necessity, and to the management of the organization.

The Bureau is not only meeting all expenses and enjoying a success in its own right, but it has been instrumental in the development of a corollary service that will be of tremendous value to the profession and likewise strengthen its own work. I refer to *The Professional Agency,* the collection service that is conducted by and for the members of this Society and the Dental Society. Without going into details I want to emphasize that the collection service is under the same management as the Bureau, and that the work of the two organizations is completely integrated. The combination of these two organizations, each serving a long-felt want in the medical profession, will enable us during the coming year to put into actual practice many of the ideas that the original sponsors of the plan never developed into any form more substantial than words.

Let me say again that from the time the Medical-Dental Service Bureau has been formed, the physicians of Essex County have received from it a total of $41,466—certainly half of which they would never have obtained otherwise; and have rendered a valuable service to their patients by relieving them from financial worries and loan sharks.

For the *Central Admitting Bureau,* Dr. Satchwell gave a verbal report of progress. He said that complete plans had been drawn up and submitted to the *Welfare Federation Committee* for consideration, and that these plans would be presented to all hospitals, and the Medical and Dental Societies, within a very short time. Dr. Satchwell stated that the committee did not want to release this plan until all agencies concerned could receive it at the same time, so that none would have any advantages over the others. As soon as the plan is made available to the agencies concerned, he said that it would be brought before the Medical Society.

PROFESSIONAL AGENCY

For the Professional Agency the following report was read by its Treasurer, Dr. J. Irving Fort:

When we organized the Professional Agency on April 1st of this year, we sent an announcement and other literature to every member of the society. We are sorry to say that a number of you evidently do not read your mail, since too many men have admitted that they filed the announcement in the waste basket without a second glance because they thought the letter came from "just another collection agency".

This "just another collection agency" attitude is one of the prime reasons for the formation of our own collection service. We knew something about the number and type of commercial agencies that had been for years preying on professional men; and we knew that the only way to have a collection service operated in a decent and effective way was to operate it ourselves. *Hence, The Professional Agency.*

And please remember the name. We selected it purposely so that, whenever you needed help on your old accounts, you would simply think of your own Professional Agency. This is much easier than trying to remember something like the Blutz Bludgeoning Company, isn't it?

It is difficult to report a great deal about anything a month old except surprise that it is growing so rapidly. Since April first we have received over $55,000 worth of old accounts for collection, from 145 doctors. These accounts represent bills unpaid by 1,600 patients. For results that have been obtained we refer you to your neighbors who have dealt with the organization. We refrain from mentioning names because some of you have given us accounts that must have traveled further in going from one commercial agency to another than any unsuccessful author's manuscripts have traveled between rejections.

However, bear this in mind. Our Professional Agency is a non-profit enterprise. We are rendering a service to the doctor; and that service means that we work every account through to a conclusion no matter how old or how small it is. We believe in doing a complete job, and doing it well. Just how well we are doing it is evidenced by an unwitting compliment paid to us within the past few weeks by a commercal collector who went to the trouble and expense of addressing individual letters to many of us pointing out that he could compete with our organization. We hope his financial resources continue to permit him to publicize The Professional Agency at his own expense!

We have found several commercial agencies, some of them used considerably by our men, who have fallen into the bad habit of failing to remit to the doctor funds that have been collected on his accounts. If any of you think this is the case with some of your accounts, we will be glad to see that any monies due to you are properly remitted by

the absent-minded agency. There is no charge for this service.

We suggest, for your own financial benefit, that you turn all your old accounts over to our Professional Agency, assured of the fact that we and the Dental Society are in complete control of the organization and alive to see that all possible is being done for our benefit.

THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

Frankln J. Tobey, M.D., Secretary

The stated meeting of the *Academy of Medicine of Northern New Jersey* was held on Thursday, April 15th, 1937, under the auspices of the Section on Surgery. President Danzis called the meeting to order at 9:15 p.m.

ELECTION OF OFFICERS

The following were elected to office:

Henry C. Barkhorn, M.D., Newark, President for two years

Charles M. Robbins, M.D., Newark, Vice-President for two years

Lee W. Hughes, M.D., Newark, Treasurer for two years

Franklin J. Tobey, M.D., Newark, Secretary for two years

Max Danzis, M.D., and E. Zeh Hawkes, M.D., Newark, Trustees for five years

Arcangelo Liva, M.D., Hackensack, Trustee for four years

Abraham Wolfson, D.D.S., Newark, Committee on Library, for five years

Royal A. Schaaf, M.D., Newark, Committee on Admission, for five years

MEMORIAL TO DR. JOHN F. HAGERTY

A resolution relative to the death of Dr. John F. Hagerty, a former President, and at the time of his death a Trustee of the Academy, was read by Dr. H. B. Epstein. President Danzis accepted the resolution for the Academy and ordered that it be inscribed in the records of the Academy. A vote of thanks was given to the committee, Drs. H. B. Epstein and Henry C. Barkhorn.

SECTION ON SURGERY

Dr. Danzis introduced Dr. Otto G. Matheke, Chairman of the Section on Surgery.

Dr. Matheke asked for the report of the Nominating Committee of the Section. Dr. H. R. Van Ness, Chairman, announced that the committee, Drs. M. H. Greifinger and W. D. Crecca, had selected John T. English, M.D., Irvington, for Chairman of the Section on Surgery, and Arthur J. Ganley, M.D., East Orange, for Secretary. The Secretary of the Section was instructed to cast a ballot for the nominees.

SCIENTIFIC PROGRAM

Dr. Matheke introduced Dr. Arthur M. Shipley, Professor of Surgery, University of Maryland.

Dr. Shipley's paper on "Surgery of the Pericardium" expressed the author's extensive knowledge of his subject, and the precise surgery necessary to alleviate this type of pathology.

The audience expressed its appreciation by a rising vote of thanks.

There being no further business, upon motion the meeting adjourned.

The following have been chosen to lead the Sections during the year:

Medicine and Pediatrics—
Benjamin Saslow, M.D., Newark, Chairman
Manfred Kraemer, M.D., Newark, Secretary

Surgery—
John T. English, M.D., Irvington, Chairman
Arthur J. Ganley, M.D., East Orange, Secretary

Eye, Ear, Nose and Throat—
James A. Fisher, M.D., Asbury Park, Chairman
William F. McKim, M.D., Newark, Secretary

Obstetrics and Gynecology—
David B. Gershenfeld, M.D., Newark, Chairman
Gerald Hayes, M.D., East Orange, Secretary

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The annual meeting of the *Gloucester County Medical Society* was held in the Homestead, Woodbury, on the evening of May 20th, 1937.

ELECTION OF OFFICERS

Officers for the coming year were elected as follows:

Oran A. Wood, Paulsboro, President
William E. Crain, Woodbury, Vice-President
C. I. Ulmer, Gibbstown, Secretary
Don B. Weems, Wenonah, Treasurer
Henry B. Diverty, Woodbury, Reporter

Trustees:
J. Harris Underwood, Woodbury, three years
William Brewer, Woodbury, two years
William W. Pedrick, Glassboro, one year

Censors:
I. W. Knight, Pitman
C. C. Sheets, Paulsboro
Ralph Moore, Woodbury

Delegates to the State Medical Society:
E. A. Livengood, three years, Swedesboro
E. A. Davis, two years, Woodbury
W. W. Pedrick, one year, Glassboro

Alternates;
Oran A. Wood, Paulsboro
W. J. Burkett, Pitman
M. F. Lummis, Pitman

Member of Nominating Committee of the State Medical Society, Dr. E. A. Downs, Woodbury
Alternate, W. W. Pedrick, Glassboro

Chosen as delegates to county societies are:

Atlantic—Drs. C. A. Bowersox, J. H. Underwood and Ralph Moore

Burlington—Drs. Oran A. Wood, H. B. Diverty and William Crain

Camden—Drs. Louis Ruttenburg, Don Weems and H. B. Diverty

Cape May—Drs. H. B. Diverty, William Brewer and F. G. Wandall

Mercer—Drs. H. L. Sinexon and C. C. Sheets
Cumberland—Drs. W. J. Burkett, I. W. Knight and M. F. Lummis
Salem—Drs. I. W. Knight, E. E. Downs and Harry Nelson

Dr. Wood announced the following committee appointments:

Public Health—Drs. I. W. Knight, T. M. Gairdner, Louis Ruttenburg, Paul Burkett and A. G. Gillis
Cancer Control—Dr. E. E. Downs
Crippled Children—Dr. Harry Nelson
Venereal Disease—Dr. B. A. Livengood
Child Welfare—Dr. Paul M. Pegau
Mental Hygiene—Dr. H. L. Sinexon
Tuberculosis—Dr. Horace M. Fooder
Program—Drs. M. F. Lummis, W. J. Burkett and Paul M. Pegau
Public Relations—Drs. R. K. Hollinshed, B. A. Livengood and E. E. Downs
Post-Graduate Course—Drs. H. B. Diverty, Harry Nelson and H. L. Sinexon
Maternal Welfare—Drs. J. H. Underwood, Dorothy Rogers and C. A. Bowersox
Medical Defense—Drs. Horace M. Fooder, W. J. Burkett and A. G. Gillis

SCIENTIFIC

Dr. Underwood read an interesting paper on "Eclampsia", and Dr. I. N. Patterson presented a case on "Carcinoma of Cardiac End of the Stomach".

There were brief remarks by Dr. Lummis, the retiring President, and Dr. Wood, his successor, who outlined his plans for the next year.

Following the meeting a buffet supper was served.

Members present were: Drs. R. K. Hollinshed and I. N. Patterson, Westville; Oran A. Wood, C. C. Sheets, Anthony DiMarino and H. L. Sinexon, of Paulsboro; H. B. Diverty, William E. Crain, Dorothy Rogers, Paul M. Pegau, Paul Burkett, J. Harris Underwood, E. E. Downs, Harry Nelson, William Brewer and C. A. Bowersox of Woodbury; C. I. Ulmer and T. M. Gairdner, of Gibbstown; Don Weems, Wenonah; Louis Ruttenburg, Mantua; Horace M. Fooder, Williamstown; B. A. Livengood, Swedesboro; W. J. Burkett and M. F. Lummis, of Pitman; Ralph Venturo, Glassboro.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The annual meeting of the *Hudson County Medical Society* was held on May 4th, 1937. The following officers were elected:

President, W. L. Williamson
Vice-President, R. L. Ballinger
Treasurer, H. Spence
Secretary, T. McG. Brennock
Reporter, J. N. Connell

Board of Trustees (three years to 1940):
T. J. Schuck A. J. Conty

Board of Censors (three years to 1940):
A. E. Jaffin

Audit Committee (three years to 1940):
M. J. Weiss

Publication Committee (three years to 1940):
S. R. Woodruff S. A. Cosgrove
W. T. Callery W. J. Snyder

Delegate to State Nominating Committee (to serve in 1938):
J. F. Londrigan

Alternate to State Nominating Committee (to serve in 1938):
F. J. McLoughlin

Committee on Constitution and By-Laws (three years to 1940):
A. P. Hasking

Legislative Committee (three years to 1940):
B. S. Pollak D. I. Nalitt
A. E. Kuhlmann

Public Health Committee (three years to 1940):
C. P. DeFuccio A. E. Jaffin
E. Halligan

Delegates to State Convention (three years to 1940):
A. P. Hasking W. A. Pinkerton
J. F. Londrigan F. J. McLoughlin
J. F. Norton D. B. Street
H. J. Perlberg G. S. Kerdasha

Alternates to State Convention (three years to 1940):
L. L. Perkel C. M. Wolbert
G. Ginsberg E. J. Daly
V. J. Sheeran P. A. Simeone
S. B. Barishaw E. Halligan

Election Committee (to serve in 1938):
S. G. Scott W. M. Doody
L. A. Schneider P. J. Bonanno
D. D. Dougherty M. Shapiro
S. S. Schept

Maternal Welfare Committee (three years to 1940):
A. A. Mutter J. H. Jentz
P. D'Acierno

Nominating Committee (to serve in 1938):
A. J. Conty E. J. Daly
W. T. Callery J. A. Botti
C. J. Larkey

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The regular monthly meeting of the *Mercer County Medical Society* was held in the Trenton Country Club on May 12, 1937, with the President, Dr. W. E. D'Arcy, presiding, and about forty members present.

DUES

Dr. Harry R. North, Chairman of the Finance Committee, reported that the House of Delegates of The Medical Society of New Jersey had voted unanimously to increase the annual State dues to fifteen dollars, as the Mercer County delegates had been instructed to vote. (Jour., May, p. 360.)

NEW MEMBERS

Dr. H. S. Magee and Dr. John J. Slaciva were elected to membership.

JUNE OUTING

Dr. Samuel Blaugrund, Chairman of the Program Committee, reported progress on plans for the annual outing to be held about the middle of June.

SCIENTIFIC

Dr. Hilton S. Read, of Atlantic City, Chairman of the Welfare Committee of the State, Society, described the work of the committee, and pointed out its value in coördinating and unifying the activities of the county societies with those of the State Society.

MIDDLESEX COUNTY

Charles H. Calvin, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on Wednesday evening, May 19th, 1937, at The Hotel Pines and was called to order by the President, John H. Rowland, M.D.

SCIENTIFIC

The scientific program of the evening was presented by Dr. Herbert Lester Moskowitz, Proctologist of the Community Hospital, Jewish Memorial Hospital, West Side Hospital, Rockaway Beach Hospital, and St. Elizabeth's Hospital, who gave a most interesting address on "Office Proctology for the General Practitioner".

(This paper will be secured for publication, if possible—The Editor.)

NEW MEMBERS

Drs. Charles E. Saulsberry, New Brunswick, was reinstated to full membership; and Ned O. Bowman, North Brunswick, to Associate Membership, by unanimous vote of the society.

LEGISLATIVE

Dr. Hoffman stated Assembly Bill A-526 was defeated. The State Society has been opposed to this bill, which was for the returning of discretionary powers to the State Board of Examiners and allowing them to play politics in making appointments.

FIELD PHYSICIAN

A letter from the State President, Dr. W. G. Herrman, was read requesting names of three applicants for positions of field physicians in the Public Health, Maternal Welfare and Child Welfare Committees. The letter was referred to a committee composed of the Public Health, Maternal Welfare, Child Welfare, and President Rowland.

A report of the Woman's Auxiliary work accomplished during the year was accepted.

Refreshments were served immediately after the meeting adjourned.

MONMOUTH COUNTY

O. R. Holters, M.D., Reporter

A meeting of the Executive Committee of the *Monmouth County Medical Society* was held at the Monmouth Memorial Hospital, Long Branch, on Monday evening, April 5th, with the President, Dr. Walter Rullman, presiding. Other members present were Drs. Fairbanks, Pregnall, Blaisdell, Nichols, Matthews, Holters, and Featherston.

A letter was received from Mr. O. N. Auer, Director of the Monmouth Memorial Hospital, Long Branch, concerning the attitude of the Medical Society in regard to Group Hospitalization Insurance. After a discussion, the following resolution was adopted:

1. The Monmouth County Medical Society approves Group Hospitalization Insurance, provided no charges for medical services are included.

2. In view of the fact that the Essex County Medical and Dental Service Bureau, with the interest of the physician in mind, has so far been unable to find a satisfactory method of eliminating medical services from Group Hosptalization, the Monmouth County Medical Society temporarily approves this plan until such time as these medical services can be eliminated.

VENEREAL DISEASE CONTROL

The Executive Committee voted to grant $50.00 to the Public Health Committee for the expenses attached to the program recently sponsored by the Sub-Committee on Vencreal Disease Control.

FEES FOR COMMITTMENT OF THE INSANE

Dr. Blaisdell reported for the Economic Committee the result of an investigation concerning the fees allowed by the various counties for examination for commitment to state institutions. He communicated with Dr. LeRoy Wilkes, State Executive Secretary, and so far it was learned that several counties allow a fee of $5.00. In one instance, the county physician is the only one who can certify for the examination. In Newark, the City Physician, or a physician delegated by him, may certify to the commitment, and the physician so delegated receives a fee of $15.00. It was reported by Dr. Fairbanks that Ocean County permits a fee of $10.00.

MONMOUTH COUNTY AT THE ANNUAL MEETING

The Executive Committee discussed the approaching convention of the New Jersey State Medical Society. As Dr. W. G. Herrman will be inducted as President, we feel that Monmouth County should be largely represented. Therefore, Dr. James Fisher has been designated to make arrangements for the accommodation of local members, and to see that our group is seated together at the President's Banquet, which will be held on April 28th. (Jour., May, p. 345.)

It was reported that the members of the Board of Governors of the Fitkin Memorial Hospital have accepted the suggestion of the Monmouth County Medical Society, and as a result no patient will be treated in the out-patient department a second time without a note from his physician, certifying that the patient is indigent and entitled to charity out-patient service. (Jour., May 1937, p. 361.)

AMENDMENTS TO CONSTITUTION

On recommendation of Dr. Clayton, the following addition to the Constitution and By-Laws is made:

Constitution: Article III, Sec. 2. Officers.—The officers of this society shall be a President, President-Elect, Secretary-Treasurer, Assistant Secretary-Treasurer, Reporter, Board of Censors, Delegates to the State Society, and an Executive Committee.

By-Laws: Chapter III, Sec. 3.—The Assistant Secretary-Treasurer shall assist the Secretary-

Treasurer in all of his duties and be familiar with the details of the office, so that he may be in a position to carry on the work in the absence of the Secretary-Treasurer, it being understood that the assistant shall succeed to the office of Secretary-Treasurer at such time as he may be elected. He will also serve as ex-officio member of all committees that include the Secretary-Treasurer.

ANNUAL MEETING

The annual meeting of the *Monmouth County Medical Society* was held at the Squankum Inn, Squankum, N. J., on Tuesday evening, April 13th, at 8:30 p.m. ,with an unusually large attendance present. The meeting began with a social dinner.

ELECTION

The following officers were elected:

President, Dr. O. K. Parry
President-Elect, Dr. Byron Blaisdell
Secretary-Treasurer, Dr. D. F. Featherston
Assistant Secretary-Treasurer, Dr. J. C. Clark
Reporter, Dr. O. R. Holters

Board of Censors:

Dr. H. S. Brown — Dr. T. E. Fenton
Dr. M. A. Quirk — Dr. L. L. Leonard
Dr. M. Woronoff

Delegates to State Convention (for three years):

Dr. W. A. Rullman; Alternate, Dr. D. V. Manahan
Dr. R. E. Watkins; Alternate, Dr. J. C. Clayton
Dr. O. R. Holters; Alternate, Dr. Wm. Matthews

Member of Nominating Committee:

Dr. R. E. Watkins; Alternate, Dr. J. C. Clayton

Executive Committee:

Dr. O. K. Parry — Dr. D. F. Featherston
Dr. Byron Blaisdell — Dr. W. Rullman

For Three Years

Dr. H. A. Kazmann — Dr. D. M. Magee
Dr. B. W. Moffatt

For Two Years

Dr. J. P. Pregnall — Dr. L. F. Albright
Dr. William Matthews

For One Year

Dr. F. J. Altschul — Dr. W. W. Gosling

DELEGATION AT STATE MEETING

It is to be noted that a large Monmouth County representatino, numbering seventy-eight, including members and their wives, attended the President's Banquet at the State Convention at Atlantic City. The chief purpose, of course, of this large attendance was to honor Dr. W. G. Herrman, the incoming President of the State Medical Society.

PERSONAL MENTION

Dr. Frank Altschul attended the meeting of the American College of Physicians in St. Louis recently.

Dr. and Mrs. L. F. Albright, of Spring Lake, also attended the convention of the American College of Physicians in St. Louis, and then made an extensive airplane trip which took them to Cuba and Mexico.

Dr. Arthur Strauss, of Long Branch, has taken his annual Spring vacation, and left on the "Conte de Savoia" for Italy last Saturday.

Dr. Walter Gosling, of Red Bank, left this week for a cruise on the United Fruit Line to Guatemala.

Dr. and Mrs. O. R. Holters returned recently from a Mediterranean cruise.

Dr. and Mrs. Stephen Sewall, of Spring Lake, and Dr. and Mrs. Victor Knapp, of Asbury Park, returned recently from a Caribbean cruise.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A regular meeting of the *Morris County Medical Society* was held the evening of Thursday, May 20th, at The New Jersey State Hospital at Greystone Park, with President Sherman in the chair, and about sixty members present.

SCIENTIFIC

Dr. Laurence M. Collins, Resident Physician, presided during the presentation of interesting cases dealing with various psychoses, and a discussion of the conditions.

1. "Clinical Symptoms and Developments of Various Physical Complaints", by Dr. Malcolm C. Taylor, Resident Physician; with a preliminary review of symptoms and presenting four individuals of the type of interesting cases encountered by the general practitioner.

2. "Involutional Melancholia in Males", presentation of neurological cases. By Dr. Thomas G. Peacock, Senior Resident Physician; with the clinical picture from the case records and presentation and demonstration of six individuals.

3. "Surgical Removal of Foreign Bodies from Gastro-Intestinal Tract", by Dr. Edward Kessler, Resident Physician; with a review of the procedures, showing x-rays, and exhibiting a variety of articles swallowed by patients and removed, unbelievable to the uninitiated, including darning needles, brooches, spoons, etc., and one instance of 103 various articles removed and the patient recovered, married and living in England.

4. "A Few Thoughts on Growth", with special reference to pituitary and thyroid disfunction. By Dr. Wilbur M. Judd, Resident Physician; and presenting an individual exhibiting the effect of glandular disfunction.

5. "Insulin Treatment in Cases of Dementia Precox", by Dr. Phyllis D. Schaefer, Resident Physician; tracing the history and regimé of treatment and results since its inception in 1930. Discussion by Dr. Archie Crandell, Resident Physician, stressing the important place of this subject on the program of the recent annual meeting of the American Psychiatric Association at Pittsburg, Pa., and indicating favorable statistical results.

MORRIS COUNTY PLANNING COUNCIL

Routine matters were considered, including proceedings of the Executive Committee, referring to the Morris County Social Planning Council and the appointment of members to represent the society in the Council; these members to be the Past-President and the President-Elect, with the active President of the society to be Chairman of the Health Committee of the Council, which would make the society's membership in the Council automatic and perpetuating.

NOMINATIONS

In behalf of Dr. Lathrope, Chairman of the Nominating Committee, who was unable to be present, Secretary Young read the report of nominations to be voted on at the annual meeting in June, as follows:

President, Dr. Louis E. Williams
Vice-President, Dr. Henry M. Larson
Secretary, Dr. George J. Young
Treasurer, Dr. J. Henry Harrington
Reporter, Dr. Marcus A. Curry

Three additional members of the Executive Committee:

Dr. Byron G. Sherman Dr. Daniel W. Teller
Dr. Thomas S. Thomas, Jr.

Members of the House of Delegates of the State Society:

To serve until 1939

Dr. F. Clyde Bowers

To serve until 1940

Dr. Byron G. Sherman Dr. Daniel W. Teller

Nominating Committee, State Society:

Dr. Bernard C. McMahon

Alternating Delegates:

Dr. William K. Booth Dr. Robt. L. Gilbertson
Dr. Edward T. Carberry Dr. J. Henry Harrington
Dr. William F. Costello Dr. George J. Young

DUES

Treasurer Young read a communication from the State Society indicating the increase of the per capita assessment of members from $13 to $15 per year, which will have no effect on the membership dues of the County Society.

STATE SOCIETY

President Sherman complimented the work of Treasurer Harrington which resulted in the society having six delegates at the recent Annual Meeting. The various delegates as called upon rendered very interesting accounts of the proceedings of the State Society; and the point was stressed of more members trying to attend the Annual Meeting of the State Society to show the other counties that there is a Morris County.

In closing, President Sherman expressed his pleasure at seeing all the delegates present and so active at the Annual Meeting of the State Society.

The evening closed with refreshments in the hospital cafeteria.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

The annual meeting of the *Passaic County Medical Society* was held on Thursday, May 13th, 1937, at the Health Center, Paterson, at nine p.m., with the President, Dr. Norman Dingman, presiding.

PUBLIC RELATIONS

Dr. Fred Vosburgh, Chairman of the Public Relations Committee, reported that a Speakers' Bureau has been organized, and to date there have been approximately twenty calls for speakers. In addition, two releases a week of publicity matters has been arranged. The work of the committee has now been well organized, and splendid coöperation on the part of the physicians secured.

CANCER CONTROL

The Cancer Control Committee, under the chairmanship of Dr. Louis Shapiro, reported that an intensive study of cancer control work was under way. The committee had visited numerous cancer control organizations, and had studied their set-ups and methods of operating. He stated that the committee had decided to hold a symposium on *Cancer of the Gastrointestinal Tract* on three evenings in the latter part of October. Two evenings would be given to professional men, and one evening to a program designed to interest the laity. Dr. Shapiro was authorized to organize sub-committees from time to time as needed to carry on this work.

MEDICAL-DENTAL SERVICE BUREAU

Dr. Johnsen gave a cumulative report on the Medical-Dental Service Bureau, showing the steady increase in the number of physicians, dentists, and hospitals using the Bureau:

Cumulative Value of Cases	Physicians No. Cases	Dentists No. Cases	Hospitals No. Cases
4/30/36—$14,600	52 86	24 44	4 48
8/31/36— 32,500	80 175	42 125	6 121
12/31/36— 52,250	92 285	53 212	6 210
4/30/37— 75,200	119 408	63 299	8 270

As of May 15, 1937—Twelve Bergen County Physicians are using the Bureau; two Bergen County hospitals are using the Bureau.

CUMULATIVE AMOUNT OF CHECKS SENT TO DOCTORS AND HOSPITALS

	Physicians	Dentists	Hospitals
4/30/36	$ 718.92	$ 496.77	$ 479.37
8/31/36	3,182.86	1,853.75	2,443.97
12/31/36	6,677.53	3,809.45	4,966.09
5/10/37	11,798.59	6,525.54	8,710.67

Due to the fact that many physicians and dentists have felt that the Bureau was of little use to them in general practice where small accounts were the rule, the Directors have added a new service,—namely a collection service on old accounts. This is a comprehensive service which is covered by a flat fee schedule, and every account is followed through by a competent investigator, and finally prosecuted by legal means, if so desired by the physician.

Announcement was also made that a comprehensive survey is now being made by the Bureau to determine the advisability of establishing a *Central Admitting Bureau.* This would be the second step in adapting the Washington Plan to Passaic and Bergen Counties.

TREASURER

The Treasurer reported that there were now 304 paid-up members, and only twenty-one delinquents. There is a balance in the treasury of $2,208.00. This puts Passaic County in third place in respect to the number of active members of the counties of the New Jersey State Medical Society.

STATE SOCIETY ANNUAL MEETING

Dr. Yates then read a summary of the Annual Meeting of the State Society at Atlantic City, covering the main accomplishments of the session.

NEW MEMBERS

The following members having been accepted and passed by the Board of Censors were unanimously elected to membership:

Dr. David Bornstein, 372 21st Ave., Paterson
Dr. Samuel Gordon, 515 Broadway, Paterson
Dr. Fred C. Hillmann, 64 Hamilton St., Paterson
Dr. Frank Manzione, Passaic County Welfare Home, Preakness
Dr. Joseph Seltzer, 557 Broadway, Paterson
Dr. William Paris, 518 East 25th St., Paterson

Junior Membership:

Dr. Theodore Markovitz, 98 Haledon Ave., Paterson

ELECTION OF OFFICERS

The following report of the Nominating Committee was then submitted:

Candidates for:
President, Dr. Fred Vosburgh
Vice-President, Dr. Louis G. Shapiro
Second Vice-President, Dr. Wayne W. Hall
Secretary, Dr. J. Allan Yager
Treasurer, Dr. Harry Wolfson
Reporter, Dr. Irving Okin

Board of Censors:
Dr. Wright MacMillan Dr. Harry S. Willard
Dr. Norman M. Dingman

Delegates to the State Society (for 1937-1938):

Dr. Yates, Chairman	Dr. Dingman
Dr. MacMillan	Dr. Johnsen
Dr. Willard	Dr. Ryan
Dr. Spickers	Dr. Cogan
Dr. Ash	Dr. Harreys
Dr. Murn	Dr. Louis Shapiro
Dr. Vosburgh	Dr. Wolfson
Dr. Hall	Dr. Yager
Dr. Okin	Dr. John Gillson

Alternate Delegates:

Dr. Ginsburg	Dr. Joseph
Dr. Theodore Graham	Dr. Leonhard
Dr. Levinsohn	Dr. Delario
Dr. Durant	

DR. DINGMAN'S EX-AUGURAL ADDRESS

Dr. Norman Dingman, the retiring President, then gave a brief summary of the accomplishments of the society during the year. First was the consolidation in the organization and effective functioning of the society which has been gradually developing during the past three years. The formation of the *Public Relations Committee* with its Speakers' Bureau under the chairmanship of Dr. Vosburgh was particularly gratifying, and this committe was doing very effective work for the society.

The next accomplishment of great value was the organization and perfecting of the *Cancer Control Committee* under the efficient chairmanship of Dr. Louis Shapiro. This was a distinctive accomplishment of this year.

The *Medical-Dental Service Bureau,* while organized under the presidency of Dr. Wright MacMillan, had developed into a far-reaching organization comprising the physicians, dentists and hospitals of both Passaic and Bergen Counties, and had now become self-supporting. The work of this organization is expanding and rendering a very effective type of service both to patients and physicians.

A *monthly Bulletin* has now become a reality; and with the Bulletin has come a permanent address for the society at 64 Hamilton Street, Paterson.

AN EXECUTIVE SECRETARY

It is hoped that a full-time or part-time Executive Secretary will soon be added to increase the effectiveness of the work of the society.

SOMERSET COUNTY

Albert W. Pigott, M.D., Reporter

The regular bi-monthly meeting of the *Somerset County Medical Society* was held on the evening of April 8th, 1937, at the Nurses' Home of the Somerset Hospital. In the absence of the President, Dr. Gray, Dr. Hegeman presided. Only twelve members were present.

A short general discussion of the Public Health Hour by various members followed the call to order.

A motion to instruct our Nominating Committeeman to support Dr. Watson B. Morris, of Union County, for Second Vice-President of the State Society at the coming State Society Convention was passed.

There being no new business nor any further discussions of old business, the meeting was adjourned, and followed by a lecture by Dr. William Goldring, of New York, on Edema, this being one of the post-graduate series of lectures.

POST-GRADUATE COURSES IN SOMERSET COUNTY

The *Somerset County Medical Society,* in coöperation with the State Medical Society and Rutgers University, conducted a post-graduate course of six lectures in *medicine.*

Under the auspices of the State Society in cooperation with the American Academy of Pediatrics and Bureau of Maternal and Child Health, the County Society also conducted a five-lecture course in *preventive pediatrics.*

The lectures in medicine were held at the Nurses' Home of the Somerset Hospital, on Thursday evenings, from March eleventh to April fifteenth inclusive; and twenty-two members were enrolled. The subjects and lecturers were as follows:

March eleventh and eighteenth, "X-ray Diagnosis and Film Interpretation", by Dr. Karl Kornblum, Assistant Professor of Radiology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

March twenty-fifth, and April first, "Proctology, Diagnosis and Treatment", by Dr. C. F. Martin, Professor of Proctology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

April eighth, "Edema", by Dr. William Goldring, Assistant Professor of Clinical Medicine, New York University Medical College, New York.

April fifteenth, "Arthritis", by Dr. Russell L. Cecil, Professor of Clinical Medicine, Cornell University Medical School, New York.

The lectures in preventive pediatrics were held on Tuesday evenings, from March twenty-third to April twentieth inclusive, and were attended by a good number of physicians and nurses. The subjects and lecturers were as follows:

March twenty-third, "Care of the Newborn", by Dr. Charles Hendee Smith, Professor of Pediatrics, New York University Medical College, New York.

March thirtieth, "Care of the Prematurely Born Infant", by Dr. Leonard T. Davidson, Attending Pediatrician, Babies' Hospital and Sloane Maternity Hospital, New York.

April sixth, "Feeding—Breast and Artificial", by Dr. Adolph DeSanctis, Professor of Pediatrics, Post-Graduate Medical College, New York.

April thirteenth, "Prevention of Nutritional Disorders and Deficiency Diseases", by Dr. Samuel Karelitz, Adjunct Professor of Pediatrics, Mt. Sinai Hospital, New York.

April twentieth, "Prevention of Communicable Diseases", by Dr. Bela Schick, Clinical Professor of Pediatrics, Columbia University Medical School, New York.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The regular meeting of the *Warren County Medical Society* was held in the Mansfield Craftsman's Club rooms, Washington, April 20th, at 3 p. m., the President, Dr. William Varney, presiding. Members present were: Drs. F. A. Shimer, P. E. Drake, Emory Krausz, of Phillipsburg; M. C. Marlatt, H. Baldauf, of Belvidere; William Varney, C. E. Lemmon, F. J. LaRiew, William Skinner, of Washington; F. W. Curtis, Stewartsville; J. Weres, Alpha; C. A. Maxwell, Hackettstown; H. B. Bossard, Phillipsburg, N. J. R. D.; Dr. G. Homer Bloom, of Easton, guest speaker.

It was voted that the society protest the membership of one of the physicians of the county on the staff of Warren Hospital, Phillipsburg, as he is not a member of the society.

NOMINATION FOR STATE OFFICER

As this society has no representation in any office or committee in the State Society, it was moved and seconded that the Secretary write each member of the Nominating Committee of the State Society suggesting the name of Dr. Frank W. Curtis, of Stewartsville, for the office of Trustee in the State Society.

Dr. James Weres gave a report of a meeting of the Maternal Welfare Committee last January in Newark.

Dr. Varney spoke at some length on the various activities of the State Society and the Welfare Committee of the State Society.

NEW MEMBERS

The Board of Censors reported favorably on the petitions of Dr. C. A. Maxwell, of Hackettstown, and Dr. G. Basillicato, of Hope, and they were elected to membership.

STERILIZATION BILL

The society went on record as favoring the sterilization bill which is before the Legislature.

SCIENTIFIC

Dr. G. Homer Bloom spoke on the use of the Anderson splint in the treatment of fractures of the long bones of the body. He demonstrated the splint and showed moving pictures of results obtained by the use of it.

The paper was discussed by several members present.

Dr. James Weres, of Alpha, the new President, was then introduced and made a few remarks.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS SINCE JULY 1, 1936

DIPHTHERIA TOXOID

County	To April 30	Month of May	Total to May 31	Average per Month
Atlantic	588	473	1061	96.4
Bergen	1283	363	1646	149.6
Burlington	996	33	1029	93.5
Camden	534	364	898	81.6
Cape May	181	197	378	34.4
Cumberland	282	5	287	26.9
Essex	9908	431	10339	939.9
Gloucester	165	179	344	31.2
Hudson	163	5	168	15.2
Hunterdon	106	186	292	26.5
Mercer	43	4	47	4.2
Middlesex	2457	75	2532	230.1
Monmouth	733	23	756	68.7
Morris	354	53	407	37.
Ocean	358	0	358	32.5
Passaic	4030	716	4746	431.4
Salem	70	210	280	25.4
Somerset	1592	3	1595	145.
Sussex	123	3	126	11.4
Union	1008	1505	2513	228.4
Warren	525	33	558	50.7
Total	25499	4861	30360	2760.

SMALLPOX VACCINE

County	To April 30	Month of May	Total to May 31	Average per Month
Atlantic	462	60	522	47.4
Bergen	1017	217	1234	112.2
Burlington	230	35	265	24.1
Camden	575	11	586	53.2
Cape May	61	8	69	6.2
Cumberland	435	31	466	42.3
Essex	4353	319	4672	424.7
Gloucester	317	11	328	29.8
Hudson	80	3	83	7.5
Hunterdon	21	244	265	24.1
Mercer	78	3	81	7.3
Middlesex	645	226	871	79.1
Monmouth	1633	30	1663	151.1
Morris	1008	24	1032	93.8
Ocean	261	0	261	23.3
Passaic	2095	413	2508	228.
Salem	34	0	34	3.1
Somerset	63	3	66	6.
Sussex	122	0	122	11.1
Union	1142	143	1285	116.8
Warren	593	47	640	58.1
Total	15225	1828	17053	1550.2

THE WOMAN'S AUXILIARY

THE WOMAN'S AUXILIARY

The Woman's Auxiliary, like its parent society, completed a year of planned activities when its officers and committees reported at the Annual Meeting on April 28, 1937. Definiteness and clearness of purpose and execution are evident in the reports which were submitted, and in the proceedings of the meeting. They show that the Auxiliary is making a definite place for itself and is doing service of essential value to the medical profession,—and this means to the people generally.

A definite field of usefulness which the Auxiliary may develop is that of research into local medical history. There are the minute books of the early days of the county medical societies, the ledgers of accounts and charges, the likenesses of the early practitioners and photographs of their homes. The wives who belong to the Daughters of the American Revolution know the value of historical facts, and the inspiration of concerted action in preserving the records.

Why not form a partnership with the D. A. R. so that the two groups of ladies may work together in historical research?

The minutes of the Annual Meeting and the reports of the officers and committees will be printed with the Official Transactions of the Annual Meeting of The Medical Society of New Jersey as a part of the supplement to the July Journal.

Camden County

By Mrs. George B. German, Chairman of Publicity

Mrs. Robert Gamon, President of the *Woman's Auxiliary to the Camden County Medical Society,* entertained the executive Board at luncheon on Friday, April 16th, at her home. The program was planned for the rest of the year.

The Auxiliary is to hold its next meeting in the form of a Spring luncheon on May fourth at the Tavistock Country Club in Haddonfield. Mrs. O. W. Saunders, Chairman of Hospitality, is in charge. She will be assisted by Mrs. Alfred Elwell, Mrs. Laurence Glover, Mrs. Henry Decker, Mrs. M. L. Wyman and Mrs. G. B. German. The reading of a one-act play will be given by Mrs. F. Harned, Mrs. H. G. Stimus and Mrs. John Lucas. Members of the Auxiliary are anticipating this luncheon with a great deal of pleasure and many are bringing guests.

At the Executive Board meeting it was voted that they give $175.00 to the Camden County Tuberculosis Association and $50.00 to the Maternal Health Center.

Essex County

The regular monthly meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held on the fourth Monday in March, at the Academy of Medicine.

A board meeting was held at 12:30 p.m., and a business meeting for members at 2:30 p.m.

At 3 p.m. there was a discussion of "Control of Social Diseases", by Dr. M. J. Exner and Dr. Robert R. Sellers, of the Newark Board of Health.

Dr. Sellers asserted that there were probably 50,000 cases of social diseases in Newark today. Many persons who contract the diseases don't recognize them until it is too late to treat them successfully.

Hudson County

Reported by Mrs. Joseph Murray

The *Woman's Auxiliary to the Medical Society of Hudson County* held a dessert bridge at the Y. W. C. A. in Jersey City on Wednesday, March 31st, at 1:30 p.m. There were thirty-nine tables in play. Several door prizes were awarded, and two lovely gfts raffled. The table prizes were very useful refrigeration sets in various colors.

Among the guests were Mrs. George E. Rogers, President of the State Auxiliary; Mrs. Don Epler, President-Elect of the State Auxiliary; Mrs. Rath Geber, President-Elect of the Essex County Auxiliary; and Mrs. Frank McCauley, a Past President of the Essex County Auxiliary.

Mrs. Louis Dodson was chairman of the affair, and her committee was as follows: Mrs. Peter Maras, Mrs. William Barbarito, Mrs. Herman Behrens, Mrs. Oscar Jacks, Mrs. Henry Klaus, Mrs. Arthur Largay, Mrs. Edward Murphy, Mrs. John Madaras, Mrs. Charles Peterson, Mrs. William Stuart, Mrs. Traugott Schuck, Mrs. Joseph Ruvane, Mrs. Edward Waters, Mrs. Harry Perlberg, Mrs. Thomas Halligan, Mrs. Samuel Barishaw, Mrs. Ellis Chapman, Mrs. Miles T. Long, Mrs. John Connell and Mrs. Charles Tannert.

The regular monthly meeting of the *Auxiliary to the Medical Society of Hudson County* was held on Monday, April 5th, at the Y. W. C. A. in Jersey City at 2 p.m., Mrs. A. E. Jaffin presiding.

There were thirty-seven members present and three guests,—Mrs. George E. Rogers, President of the State Auxiliary; Mrs. Don Eppler, President-Elect of the State Auxiliary; and Mrs. Theodore Teimer, the State Chairman of the Society for the Relief of Widows and Orphans of Physicians of New Jersey. We also welcomed back one of our charter members, Mrs. Reeve E. Ballinger, of North Arlington, who has been inactive for several years.

Mrs. Edward Waters, Recording Secretary, read a letter from Dr. Henry C. Barkhorn, of Newark, inviting the members of the Auxiliary to hear a talk by Dr. Frederick Tilney, of New York, on "The Evolution of the Human Brain" at the Academy of Medicine of Northern New Jersey in Newark on April 22nd at 8 p.m.

Mrs. James Murphy, Public Relations Chairman, invited the members of the Auxiliary to a reciprocity meeting which is being held by the Mothers' Club of the Lafayette Reformed Church on April 21st in the afternoon.

Mrs. Louis Dodson, Entertainment Chairman, reported that her committee is planning a supper dance to be held at "The Brook" in Millburn,, N. J., on April 21. The committee is also working on our annual Play Day, which will be held the last week in May.

Mrs. Jaffin announced that the Annual Convention will take place in Atlantic City the week of Apirl 26th. The delegates named by her: Mrs. A. E. Jaffin, Mrs. William Freile, Mrs. C. B. Kelley, Mrs. Miles T. Long, Mrs. Edward Waters, Mrs. James Murphy. Mrs. Robert Stockfish, Mrs. Abraham Schulman, Mrs. Arthur Largay, Mrs. Peter Maras and Mrs. J. J. O'Connor were named as alternates.

Mrs. James Murphy, our Nominating Chairman, read the following slate of officers:

President, Mrs. C. B. Kelley
President-Elect, Mrs. Arthur Largay
First Vice-President, Mrs. Ellis Chapman
Second Vice-President, Mrs. Charles Tannert
Recording Secretary, Mrs. Andrew Ruoff
Treasurer, Mrs. Harry Perlberg

The members of the Auxiliary accepted the slate as read.

Mrs. Rogers, Mrs. Epler, and Mrs. Teimer each gave a very brief but interesting talk, after which tea and a social hour followed.

Mrs. Rogers poured most graciously, and several members of the Auxiliary served as hostesses.

Mercer County

Reported by Mrs. Leonard Friedman

The *Woman's Auxiliary to the Mercer County Medical Society* held an all-day meeting at the Municipal Colony, on Monday, April 12th. Surgical dressings for the institution were made throughout the day.

Mrs. C. Chester Chianese, our President, conducted a business session in the morning.

Mrs. L. L. Friedman, Secretary, read a brief résumé of our Public Relations Tea given last month, at which time we were highly honored by having as our guest speaker the distinguished Governor Harold G. Hoffman.

Mrs. Ed. K. Hawke, Treasurer, gave her report and asked that two auditors be appointed to audit her books.

Instructions to delegates and alternates were read. Those appointed are: Mrs. C. Chester Chianese, recording delegate; Mrs. Ralph Belford, alternate; Mrs. William C. Ivins, delegate, and Mrs. F. A. McGuigan, alternate; Mrs. D. M. Yazujian, delegate, and Mrs. Alton S. Fell, alternate.

Entry blanks were distributed to those who are to participate in the Art, Hobby, and Medical History Exhibit. Mrs. H. Don Cowlbeck is our County Committee Chairman. Members were urged to attend the Atlantic City Convention if possible. Questionnaires were signed by members to be returned to our State Chairman of Public Relations.

A delightful chat on "Beauty" by charming Miss Langroovier was attentively enjoyed by our members.

At one o'clock over forty members were guests of the institution at a delicious luncheon served under the direction of the dietician, Miss Turner, with Mrs. Paul Klempner in charge of reservations. Following, Dr. Lawrence H. Rogers, Medical Supervisor of Municipal Colony, who had joined us at luncheon, welcomed us very kindly. He traced the history of the Colony from its origin—an old dilapidated small building with a barn in addition. Here about a dozen contagious cases were treated. He went on telling of the hard struggles to its present day; a fine development twenty-five years later with many buildings. He also spoke on Socialized Medicine, stating that "the integrity of the practice of medicine is at stake"; and he praised the Medical Auxiliary for our firm stand against it.

Mr. John L. Irwin, Executive Secretary of the Community Chest, was next presented. He gave a diligent talk on the three D's, that is, Delinquency, Dependency, and Disease.

Before we left, the members were taken on a tour of the Colony under the guidance of Mrs. Anna M. Walker, Supervisor of Nurses.

We spent a very enjoyable, friendly day.

Our next meeting will be held at the State Hospital, May 10th.

Middlesex County

Reported by Mrs. N. S. McLeod

A regular meeting of the *Auxiliary to the Middlesex County Medical Society* was held at The Pines, February 17th, 1937. The President, Mrs. J. J. Mann, Perth Amboy, N. J., conducted the business meeting.

Chairmen of the various committees were appointed.

A motion was made and passed that the Entertainment and Program Committees be consolidated, and Mrs. L. S. Downs, Carteret, N. J., was appointed Chairman.

A motion was also made and passed that a Past President's Pin be purchased and presented to Mrs. B. M. Howley, Highland Park, N. J.

There was no meeting in January due to inclement weather.

The next meeting of the Auxiliary was in the form of a Bridge-Luncheon, held April 14th, 1937, at the State Home for Boys, Jamesburg, N. J.

Mrs. M. Molitch was chairman, assisted by her husband, Dr. M. Molitch.

A short business meeting, presided over by the President, Mrs. J. J. Mann, was held after the

luncheon. At this time the committee chairman gave the reports of their activities.

The Public Relations Chairman reported that thirty-six speakers had appeared before lay organizations, such as Rotary, Kiwanis, Women's Clubs, Parent-Teacher Associations, Y. M. C. A. and Y. M. H. A.

Delegates appointed to the State Convention were:

Delegates	*Alternates*
Mrs. J. J. Mann	Mrs. L. S. Downs
Mrs. H. Strandberg	Mrs. William Stein
Mrs. M. Molitch	Mrs. C. Hofer

Mrs. Mann announced that Mrs. B. M. Howley, our Past President, had been appointed to the State Board of Directors of the Auxiliary to the Medical Society, State of New Jersey.

Mrs. Molitch reported progress of the Art, Hobby, and Historical Exhibit and that Middlesex County would be represented this year.

There will be an Executive Board meeting and tea for officers and committee chairmen at the home of Mrs. J. J. Mann, President, Perth Amboy, N. J., urer's report, the Corresponding Secretary, Mrs. by-laws will be permanently adopted.

The next meeting of the Auxiliary will be held the third Wednesday in May.

Somerset County

Mrs. C. F. Halsted, Reporter

The Annual Meeting of the *Woman's Auxiliary to the Somerset County Medical Society* was held at the Nurses' Home, Somerset Hospital, Thursday, April 8th, at 8:30 p. m., the President, Mrs. William B. Gray, presiding.

After the usual reading of minutes and the Treas- Meigh, reported the announcements for each meeting had been duly sent each member.

Mrs. A. L. Stillwell, Chairman of the Society for the Relief of Widows and Orphans, reported finding one physician who k ew nothing of it.

Mrs. Lancelot Ely, Chairman of Archives, said that she had sent the name of Mrs. Elizabeth R. Cooper to Mrs. Hunter for the Book of Memories.

Mrs. Stillwell read a short history of the life of Mrs. Cooper, paying sincere tribute to her as wife and mother of physicians.

Mrs. Edgar T. Flint, Chairman of Public Health and Public Relations, reported very little coöperation in filling out the questionnaire sent out by the State Chairman; only ten members responded.

The following officers were elected:

President, Mrs. D. S. Renner
President-Elect, Mrs. Edgar T. Flint
Vice-President, Mrs. A. Longstreet Stillwell
Secretary, Mrs. C. F. Halsted
Treasurer, Mrs. J. L. Young

Directors for two years: Mrs. F. L. Field, Mrs. T. H. Flynn.

Plans for a card party were again discussed. It was decided that each member be responsible for a small party to raise money and forward it to the Treasurer.

Mrs. Stillwell read a lengthy dissertation on "Socialized Medicine", written by Dr. J. B. Morrison, Secretary of The Medical Society of New Jersey.

Union County

Reported by Mrs. Herschel S. Murphy

The *Woman's Auxiliary to the Union County Medical Society* held a tea Tuesday afternoon, March 23rd, at the home of Dr. and Mrs. F. A. Kinch, Westfield. It was given for lay organizations as well as the Auxiliary, and was very well attended.

After a few words of greeting by the President, Mrs. F. B. Gilpin, Cranford, introduced the speaker, Dr. Henry C. Barkhorn. He spoke on "The Cause and Cure of Deafness". He said there were very few people who were totally deaf; there is an island of hearing. Dr. Barkhorn discussed deafness in the child and in the adult, telling of the marvelous work done in finding the cases in schools and of the "education crusade which has gone far". There is such a strong feeling of inferiority which must be overcome in those who are deaf. The Leagues for the Hard of Hearing is doing a great deal of good work in this field. Dr. Barkhorn illustrated his talk with models, charts and instruments for detecting deafness and for the treatment.

Mrs. G. Rogers said a few works of greeting, and of our aims, sociability, and public relations.

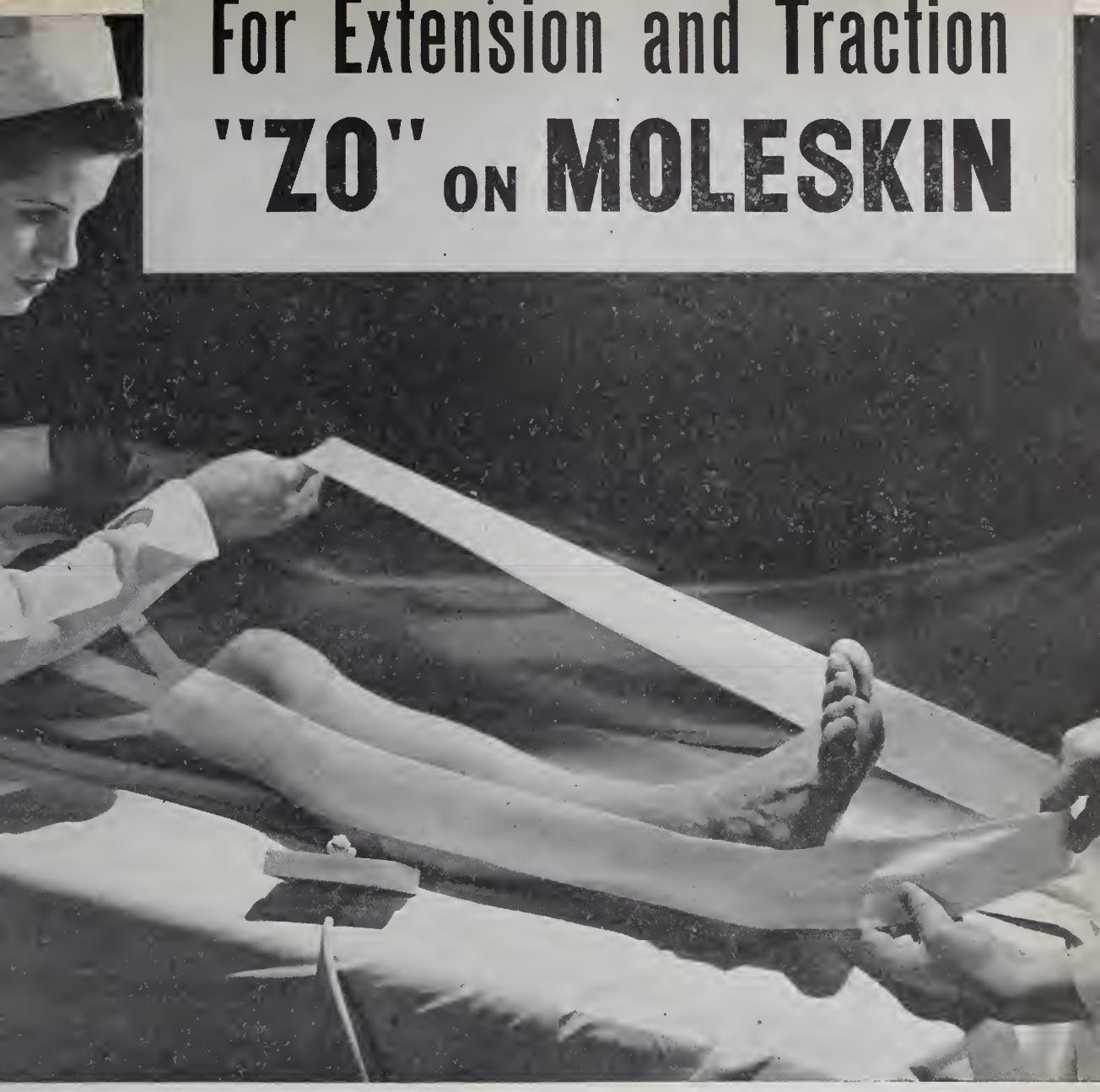
It has been announced that the Auxiliary had won a $50 prize, one of the three awarded by Mrs. MacRenolds, of Texas, Past President of the Woman's Auxiliary of the American Medical Society. These awards were made for the Auxiliary securing the greatest number of subscriptions to the Hygeia Magazine, which is edited by the A. M. A.

Following this, refreshments were served by the hostess. Mrs. G. A. Rogers, State Auxiliary President, and our local President, Mrs. F. B. Gilpin, poured.

The *Woman's Auxiliary to the Union County Medical Society* held its annual meeting Wednesday evening at the home of Dr. and Mrs. H. H. Bowles, of Summit. Before the business meeting, Mr. Milton Koos, of Koos Brothers, Rahway, showed a sound-movie, "Forest Treasurers". Wood gems were selected from the jungles of Africa, Australia, India and from the forests of the United States. All these fine woods, such as mahogany, oak, satin-wood, were taken to mills. Here they were transformed into veneers and ply-wood of beautifully matched grains for use in furniture. Samples of the finished products were shown both in room settings and by themselves.

Following this the regular business was discussed, and the annual reports were read. At the close of the meeting, Mrs. H. V. Hubbard, of Plainfield, in behalf of the Auxiliary, presented the outgoing President, Mrs. F. B. Gilpin, with a Past President's Pin in appreciation of her work. Refreshments were then served. Mrs. D. R. McElhinney, the incoming President, poured; Mrs. W. J. Hallock, Mrs. George Knauer and Mrs. J. M. Hanrahan assisted the hostess.

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Magnesium (Mg)	5.8	0.34
Sodium (Na)	5.6	0.33
Potassium (K)	Trace	Trace
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Carbonic Acid Free (CO_2)	7.0	0.41
Sulphuric Acid, Radical (SO_4)	27.1	1.58
Nitric Acid Radical (NO_3)	1.8	0.11
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Hydrogen Ion concentration, pH		
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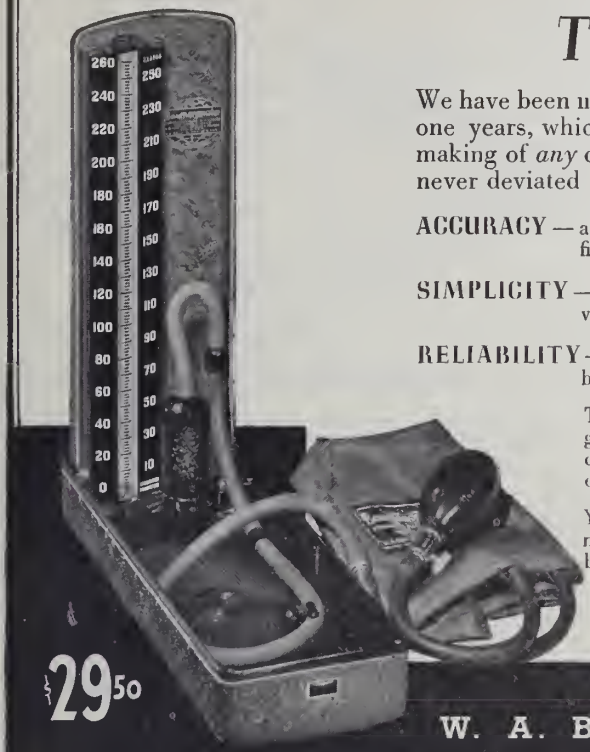
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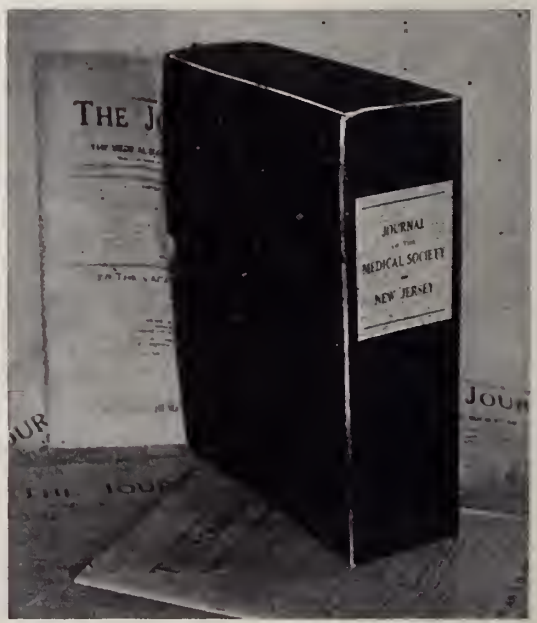
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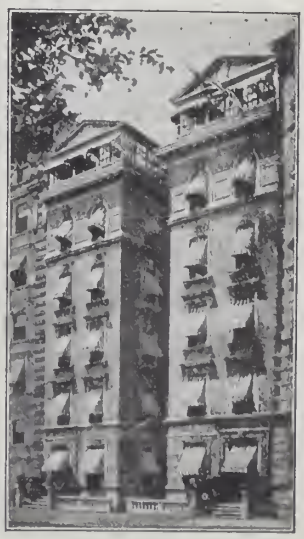
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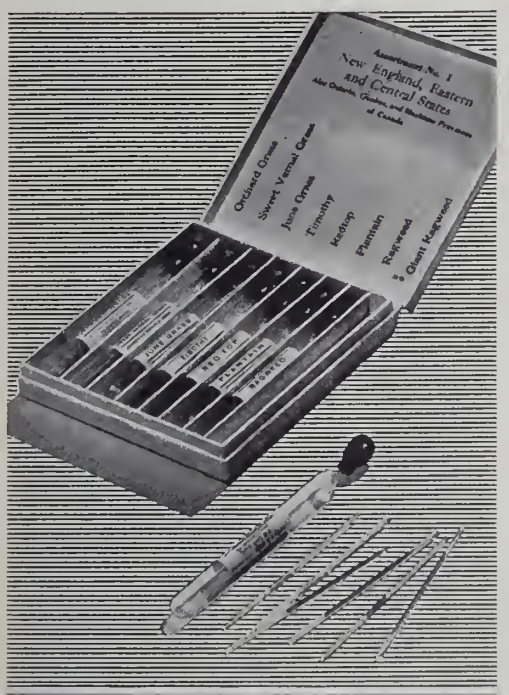
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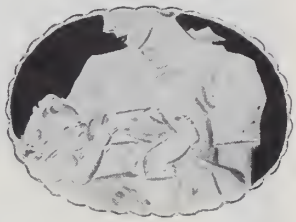
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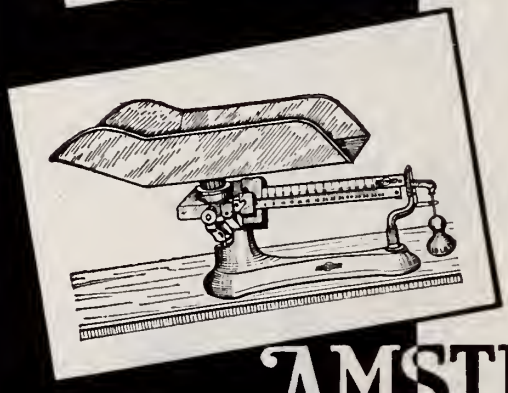
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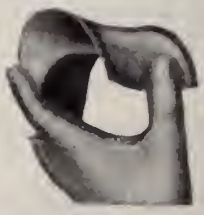
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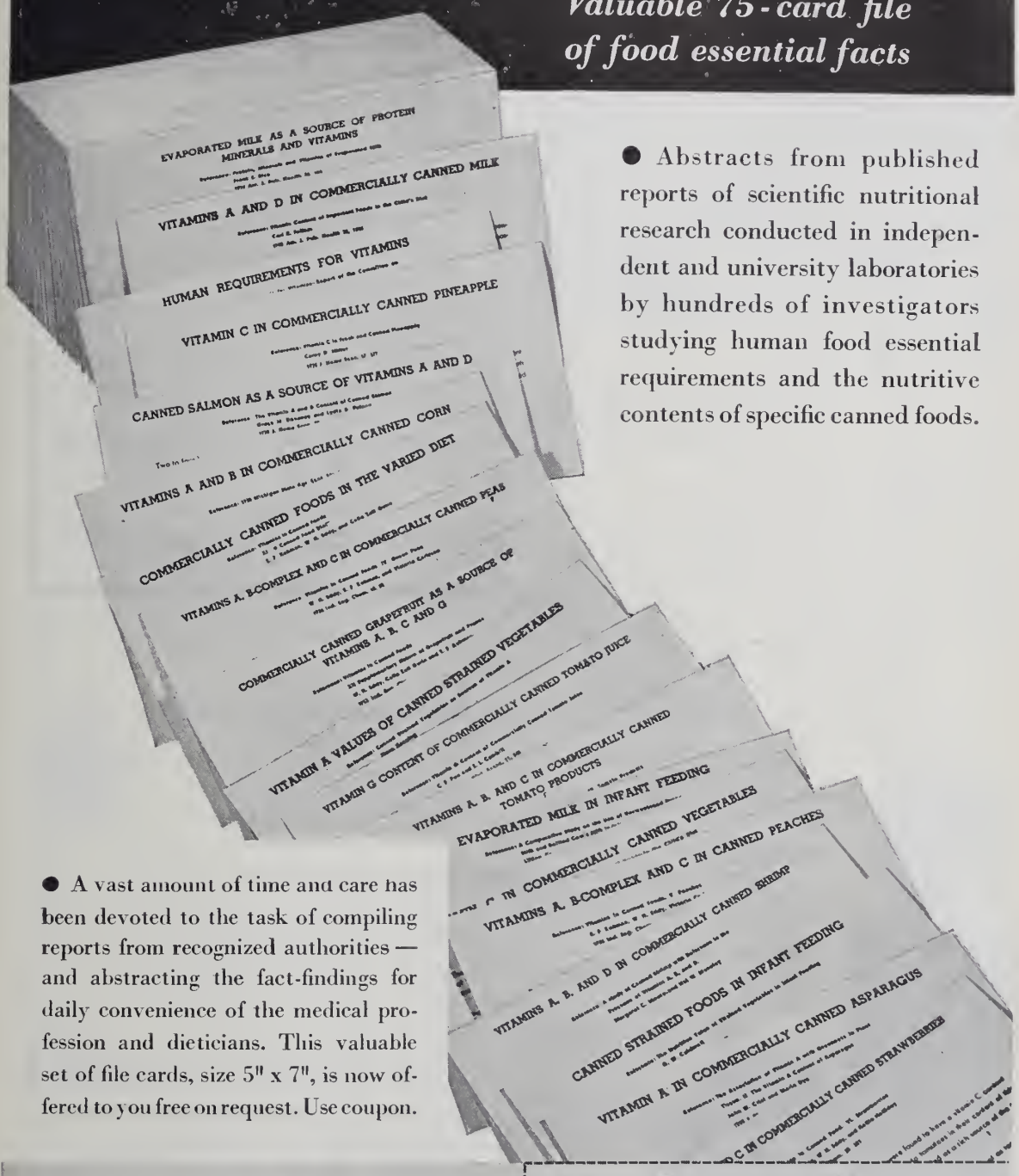
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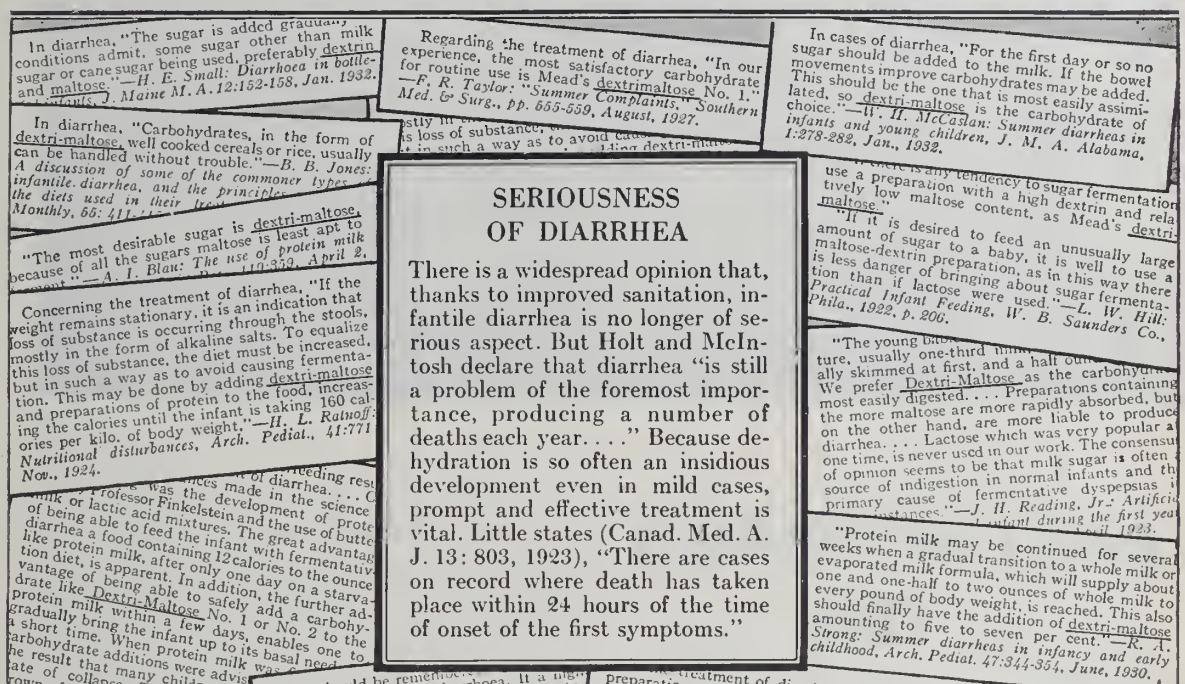
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EDITORIALS

New Year Opportunities

This July issue of The Journal of The Medical Society of New Jersey looks backward as well as forward. The House of Delegates passed judgment upon the reports of the work of the officers and committees of the State Society during the year that closed on April 29, 1937. It also used those reports as the basis of plans for the coming year. Many experienced officers and committeemen are retained in their former positions in order that they may continue the excellent work which they have initiated; and others are advanced to positions of higher usefulness. Adding the officers and committeemen of the county societies, the State Society can count on over a thousand members to render advice in improving the delivery of medical services to all classes of people.

The basic principle on which The Medical Society of New Jersey and its component county societies work is to develop the distribution of medical services piece by piece, and item by item. While the Society makes extensive studies of medical services, it does not wait until the studies are completed; but it applies a plan for service as soon as its acceptance is possible in a community. New Jersey is dotted with local projects that are developed and conducted by local groups and county societies. A demonstration in any locality is an example and inspiration which other local units imitate, and often develop beyond the standards of the society that initiates it.

The Journal is the available repository of information regarding all forms of progress in the practice of medicine throughout the State. Its monthly reports of the meetings of the county societies are filled with descriptions of activities undertaken as the result of demonstrations by other county societies and the State Society. Practically every one of the two hundred officers and committeemen of the State Society is also on the list of officers of his county society. The Chairman of the Welfare Committee, for example, is President of his county society. The State Society is a graduate school of medical leaders; and on the other hand, the county societies are schools in medical leadership in wider fields of activities.

The new year of organized medicine in New Jersey opens more auspiciously than ever before, for it is built on the sure foundation of local medical accomplishments.

Dynamic Medical Practice

Dr. W. G. Herrman, President of The Medical Society of New Jersey, in an address before the Welfare Committee on June 20, made a clear distinction between the "Static" and the "Dynamic" methods of the practice of medicine, which has an important application in the present discussion regarding the distribution of medical services.

The practice of medicine is not *static,* as it was for a thousand years up to the time of the founding of The Medical Society of New Jersey in 1766 by a group of the younger and more progressive physicians of that time. The practice of medicine is now *dynamic,* like the professions of engineering and chemistry, by which conditions of modern life are molded.

Every county medical society is a *continuation school* in dynamic, up-to-date medical practice, in which the best practitioners in the land are pleased to donate their services as teachers. The Medical Society of New Jersey has *Graduate Education* as one of its major activities, whose services are free to every physician through his county medical society. The physician who does not avail himself of this form of instruction soon becomes *static* in his professional equipment; and behind the times in his methods of practice.

There are also principles of the "Distribution of medical services", which deal essentially with the "Acceptance of those services by the people". Crude names for those principles are "Medical Economics", and "Medical Salesmanship".

Every physician in these modern days is dependent upon the services of allied groups, among which the following may be enumerated in the order of their development:

Nurses
Hospitals
Laboratories
Welfare groups, both official and voluntary.

Each of those groups is highly organized both for giving service, and also for educating the people as to the scope and value of their services. They hold great conventions which are described in newspapers and in their own periodicals, and are extensively quoted in the daily press and popular magazines. The effect of their publicity and propaganda is that many people consider most practicing physicians to be "Static" in their outlook, and in their methods of practice. This opinion is encouraged by the volume on the "Costs of Medical Care", which was financed by great Medical Foundations; and by the recent report of "The American Foundation Studies in Government", which is based on the opinions of several hundred doctors regarding the present deficiencies in the acceptance of medical services by the people generally.

The two conclusions of both of these widely-publicized studies may be stated as follows:

First, as to the diagnosis of medical conditions: *A large proportion of the people are not availing themselves of modern medical services.*

Second, as to prognosis and treatment: *The people will accept high-class medical services, provided they are made available at public expense.*

THE OPINION OF PHYSICIANS IN PRIVATE PRACTICE

Physicians generally agree with the first conclusion,—that regarding the diagnosis of present conditions.

They do not agree with the second conclusion,—that medical services can be supplied universally and effectively under government control. The basis for this opinion is the very nature of medical services itself.

MASS VERSUS PERSONAL SERVICE

Practicing physicians and welfare workers agree that the actual delivery of a medical service must be given by an *individual physician to an individual patient.* It is the law of the land that no group of persons,—medical, corporate, or governmental,—can practice medicine; but the doctor who actually examines and treats a person is responsible for his own professional acts, and he cannot divulge any secret which he learns from his patient, without the consent of that patient.

The practice of medicine is a "Personal" service in distinction from a "Mass" action.

The success of the practice of medicine under control of any third party depends on the personal service of an individual doctor to an individual patient. However, it does not follow that non-medical agencies—governmental or voluntary—have no place in medical practice,—for every doctor concedes that those agencies should supply accessory services—such as nursing and laboratory—to those patients who are unable to secure them by their own initiative and efforts. For example, the doctor who is opposed to "State Medicine" demands that the government shall pay him for his services to the indigent and those in lowest group of wage earners.

The vital objection to any form of "State" medicine is that it invariably results in a "Static" form of medical practice, in distinction from the "Dynamic". The static form of practice is done according to fixed rules, rather than by the adaptation of the doctor's methods to the individual patient, with due consideration for his personal feelings and his real needs. For example, ward patients in hospitals object to the "Impersonal", machine-like service which they sometimes receive, even though that service is highly scientific.

Two methods are proposed for promoting the dynamic practice of medicine.

First is the method of *revolution,* or *dictatorship,* imposed by higher authority government officials, under the influence of endowed Foundations, led by cloistered philosophers who propose to hire physicians to deliver medical services which shall be of a highly scientific nature. This is the *mass* methods, which invariably becomes *static,* because no physician can be original and progressive when he is directed by a group of laymen whose knowledge is theoretical.

Second is the method of *evolution,* in which the medical society directs and inspires the scientific education of its members and also of the officials who supply accessory services of nursing and welfare relief.

Local groups of physicians educate the leaders of lay groups engaged in delivering services in nursing and relief.

County medical societies educate welfare officials in economic methods of dispensing medical services to the needy.

The State Medical Society is the adviser of the State Department of Health, the Department of Education, the Department of Institutions and Agencies, and all other State-wide groups which are engaged either directly or indirectly in supplying services that are accessory to those of health.

The American Medical Association is the natural adviser of Federal officials whose proper field is nation-wide in its scope.

The medical organizations of New Jersey,—local, county, and State,—are *aggressive* and *dynamic* in their leadership of the allied groups engaged in the distribution of medical services.

The national medical organization has the opportunity to assume an attitude that is aggressive and dynamic in the face of propositions to establish socialized methods of the distribution of medical services. The American Medical Association offers to place the results of its extensive studies at the disposal of government officials, *provided the officials seek its aid.* The Medical Society of New Jersey asks the American Medical Association to lead, rather than follow, in developing and applying methods of distributing medical services.

A National Health Policy

Any new movement of great magnitude is difficult to understand while it is in a stage of development. The subject of "A National Health Policy" was introduced in the House of Delegates of the American Medical Association by the delegation from New York State, and was the cause of considerable controversy which is still going on in medical circles. The movement has resolved itself into two parts:

1. Internal relations, or organization.
2. External contacts, or those with welfare and political agencies.

In order to understand the discussion, the basic facts will be stated in chronological order.

1. Late in the Fall of 1936 President Roosevelt announced his intention to attempt to reorganize the Departments of the United States Government in order to promote efficiency of administration. This announcement aroused medical leaders to give serious thought to the development of a nation-wide policy of medical practice.

2. The Trustees of the American Medical Association, at their meeting on January 8, 1937, considered the subject of "A National Health Policy", and adopted two resolutions on:

a. The establishment of a National Department of Health.

b. Provision for the care of the indigent.

3. The first resolution called for the establishment of a National Department of Health which should be independent of all other departments or sub-divisions of government. This proposition was reported in the A. M. A. Journal of January 16, 1937, page 208; it was quoted in full in the Trustees' Annual Report as printed in the A. M. A. Journal of May 1, 1937, page 1529; and was quoted again in the Transactions of the A. M. A. House of Delegates in the A. M. A. Journal of June 26, 1937, page 2220. This report was approved by the A. M. A. House of Delegates (A. M. A. Jour., June 26, 1937, p. 2221).

4. The Medical Society of the State of New York entered the scene of action on May 24, 1937, by adopting "Principles and Proposals for a National Health Policy"; and voting to refer them to the A. M. A. House of Delegates on June 7 (New York State Journal of Medicine, July 1, 1937, p. 1225, and p. 1228). The New York Principles emphasized the need of "Adequate Medical Care", and suggested a committee to define the term. The New York plan also included provision for the care of the indigent.

5. The New York Resolutions and Principles were introduced in the A. M. A. House of Delegates on June 7, 1937 (A. M. A. Journal, June 19, 1937, p. 2142). They were referred to the "Reference Committee on Executive Session", whose Chairman, Dr. Thomas A. McGoldrick, of Brooklyn, was also Chairman of the Reference Committee of the New York House of Delegates, which had the "Proposals" in charge.

6. The report of the Reference Committee to the A. M. A. House of Delegates was as follows:

"The subject is too important, too vast, and too widespread in its implication to be justly and adequately considered in a few hours, or even a few days, by any reference committee. It recommends that the resolution be referred to the Board of Trustees of the A. M. A. for consideration and action at the earliest possible time." (A. M. A. Jour., June 26, 1937. p. 2217.)

7. The action of the House of Delegates in regard to the resolution is briefly recorded as follows:

"The report was referred back to the reference committee." (A. M. A. Jour., June 26, p. 2218.)

8. The Reference Committee on Executive Session reported again on June 9, as follows:

"Your Reference Committee has carefully considered the resolutions on 'A National Health Program', * * * and has held hearings at which the details of the principles and proposals were freely discussed.

"The Board of Trustees has already reported to this House of Delegates its considered opinion pertaining to the reorganization into one consolidated department of the activities of the Federal government, having to do with the promotion of health and the prevention of disease. Copies of this statement * * * were transmitted to the President of the United States, and to others in official positions in Washington, and the attention of constituent State medical associations was especially called to the action of the Board as follows:"

This is the action to which reference is made in section two of this review.

9. The Reference Committee continued its report on other phases of the New York Resolutions, as follows:

"Since the House of Delegates during this session has already approved this action of the Board of Trustees, your reference committee

deems it unnecessary to submit for your consideration that portion of the resolutions which deals with this subject.

"Your reference committee recognizes that certain principles stated in the resolutions presented by Dr. Kopetzky (of the New York Delegates) have been considered by the House of Delegates on previous occasions and are matters of record. These include, for example, the recognition of the primary importance of public health, the opposition to compulsory sickness insurance, and the separation of the problem on economic need and the distribution of medical service."

The A. M. A. House of Delegates seems to have been content to reaffirm the opinion which the Trustees had expressed on January 8, 1937.

10. The Reference Committee also considered the subject of "Medical Care of the Indigent", which the Trustees had considered on January 8, 1937. The report on this subject was printed in the A. M. A. Journal of January 16, 1937, page 209; and was reprinted with the Trustees' annual report in the A. M. A. Journal of May 1, 1937, page 1529; and was printed for the third time in the Journal of June 26, 1937, p. 2220, as part of the minutes of the A. M. A. House of Delegates.

11. There is nothing on record regarding any action taken by the A. M. A. on the subject of "Adequate Medical Care" and its definition which was emphasized in the New York resolutions and principles.

12. The final report of the Reference Committee on Executive Session made two suggestions, which were as follows:

"Your reference committee recommends that the bureaus, councils and committees of the Association continue their studies of the need for and the methods of distributing medical care, to the end that the American Medical Association shall continue to do everything possible to promote and to protect the health of the American people.

"The American Medical Association reaffirms its willingness on receipt of direct request to coöperate with any governmental or other qualified agency and to make available the information, observations and results of investigation together with any facilities of the Association."

The language of these two paragraphs leaves the reader in doubt as to their meaning.

13. A feature of the proceedings of the House of Delegates was the address of United States Senator J. Hamilton Lewis, who styled himself "Senate Whip and Parliamentarian". The speech is reported in the A. M. A. Journal, June 26, 1937, p. 2221, and in it he says that he came directly from President Roosevelt, whose word was that he wished the doctors success in their meeting.

Senator Lewis compared the physician with the lawyer, and said that the government is trying to control both. The judge assigns a lawyer to defend an indigent person; and the Senator would have a doctor compelled to treat an indigent patient to whom a government officer assigns him, but to be authorized to present a proper bill for his services.

The closing words of the Senator's address were in accord with the opinions of medical leaders. He asked the doctors to state two things:

1. The best system for delivering medical services to the needy.

2. The qualifications of those who shall direct the operation of the system.

As a matter of fact, these two objectives are those toward which the Welfare Committee of The Medical Society of New Jersey is striving.

Leading or Led

It might help some of our members to clarify the reason for their coöperating in Social Security projects if they would realize that The Medical Society of New Jersey is organizing and training its members in teamwork, under the supervision of its own officers. The primary purpose in doing this is not only to improve our distribution of medical services in New Jersey, but also to insure our own control of the practice of medicine in the face of the looming threat of government control of medical service which is materializing in New Jersey. We have already established the organization, supervision, and control of our own members according to *our own* ideas and plans. If the government intends to practice medicine in New Jersey, it can purchase medical services from an already established and functioning organization, such as The Medical Society of New Jersey, more economically and effectively than by setting up a competing system under official direction.

Every doctor in New Jersey must face this question—"Do you wish to work for the Government; or will you help to establish a system of practice which you yourself will conduct and control?"

L. A. W.

Fashion or Fumble!

We have been boasting of the scientific strides of American Medicine. We have been coasting along with an archaic system of medical economics that many admit would permit of modernization with profit to the dispensers as well as the recipients of medical care in this country.

A pattern of practice is being cut, under which certain medical services will be rendered. The Medical Society of New Jersey can reflect with pride on the fact that for some years it has been offering constructive criticism to the reactionary policy of "Let's wait and see what happens."

With its years of unselfish devotion to the physical welfare of all groups, no element is in better position to fashion the proper pattern than the forces of Organized Medicine. If the politicians cut the pattern to the benefit of anyone, it will be of historical moment if any but the politicians profit by it.

Opportunity to make a monumental contribution to all mankind is at hand. Will Organized Medicine fashion it, or fumble it?

Hilton S. Read.

The A. M. A. Journal in New Jersey

An accurate measure of the support which physicians of a State give to the American Medical Association is the percentage of those doctors receiving the A. M. A. Journal.

An editorial in the New Jersey Journal of October, 1934, page 554, contained a table showing the percentage of physicians in the several States who were then receiving the A. M. A. Journal. New Jersey headed the list with 65 per cent.

This figure was doubted by the A. M. A. officials, who inquired as to the source of the figures, but the record is confirmed by the table in the annual report of the A. M. A. Trustees to the House of Delegates, as printed in the A. M. A. Journal of May 1, 1937, page 1510.

This table shows that in the Spring of 1937, 69 per cent of the physicians of New Jersey were subscribers to the Journal of the A. M. A. This is a gain of four per cent of the proportion recorded in the New Jersey table in 1934.

ORIGINAL ARTICLES

THE NEW JERSEY HOSPITAL ASSOCIATION

PAPERS AND DISCUSSIONS AT THE WINTER CONFERENCE

January 27, 1937

For description and program see p. 466.

THE DOCTOR'S VIEW OF HOSPITALIZATION INSURANCE

By Edgar A. Ill, M.D., Newark, N. J.
President, Essex County Medical Society

An address before the New Jersey Hospital Association in Newark on January 27, 1937.

After the four years that the Essex County hospitals have pioneered in the development of their Hospital Service Plan, it would be "carrying coals to Newcastle" for me to attempt to discuss the technical aspects of the experience which you as hospital administrators have already had with the operation of the hospital service plan. My purpose this evening will be to present for discussion several points as they particularly affect the medical profession, in the hope that they may be given serious consideration and that the mutual interests of the profession and the hospitals will be furthered by your delibertion of them.

THE ESSEX COUNTY HOSPITAL SERVICE PLAN

When the Hospital Service Plan was first organized in Essex County in January, 1933, the Essex County Medical Society did not care to endorse a plan absolutely unknown to them. We doctors were asked to endorse a plan which we had not been given an opportunity to examine. However, we did not oppose it, and several o fthe members of this society, as individuals, actively participated in its development. After two and one-half years' experience with the plan, we decided that it had not interfered in any way with the relationships of patients to their physicians. We were informed that the plan had made a distinct contribution to the financial stability of hospitals. We also realized that the plan directly improved our financial position, and greatly aided our Medical-Dental Service Bureau. For these reasons we officially endorsed the plan as it was being administered in Essex County. At the present time the President-Elect of the Essex County Medical Society automatically becomes a member of the Executive Committee of the Board of Trustees of the Hospital Service Plan of New Jersey.

That action on the part of the Medical Society in the late Summer of 1935, and the inclusion of our representative on the Board of the Hospital Council, I believe, is one of the milestones along the road toward helpful cooperation which the medical profession and the hospitals are traveling together. I feel that the mutual confidence which has been engendered by the many joint approaches which the medical profession and the hospitals of Essex County have recently made to their mutual problems is altogether the healthiest and surest way to safeguard the interests of the medical profession as they relate to hospital problems.

X-RAY AND LABORATORY SERVICE

As an example, let me speak specifically of the discussion which has recently transpired regarding the provision of x-ray and laboratory service under the hospital service plan. On the surface, it would appear that a medical society which felt very strongly that medical service should never be supplied on any "socialized" or "pre-payment" basis could do nothing but disapprove the inclusion of x-ray and laboratory work in a hospital service plan, since these certainly constitute medical care. However, in conference with the presidents of two professional radiological societies, we

found that most roentgenologists and pathologists doing work in hospitals for in-patients had, years ago, entered into the contract practice of medicine with the hospitals. Thus, the public has become educated to seeing charges for x-ray and laboratory work appear on a hospital bill, and not on the billhead of a physician. In the public's mind these services are no longer medical services, but have become part of the service which the public expects from a hospital. Obviously, then, if the hospital alters the method whereby its patients pay for the service which is rendered to these patients, it is not changing the fundamental relationship which now exists between the roentgenologist or pathologist and his patient. That was changed years ago when these specialists entered into contracts for handling work in hospitals, or in some cases even accepted straight salaries from hospitals.

The real concern of the roentgenologists and pathologists was how they should be compensated for services rendered to hospital service plan cases, and not any desire to return to private practice. The Medical Society and the Hospital Service Plan suggested to these specialists that, if compensation is the problem, a fair solution would be to have the hospital credit as income to the x-ray department and laboratory departments the same proportion of the total payments made on behalf of hospital service plan patients that regular x-ray department and laboratory income bears to the total general income of the hospital, exclusive of income from hospital service plan patients.

Thus, upon critical examination, we find one of the elementary problems under discussion between the medical profession and hospital service plans is, in effect, an attempt to distinguish between *hospital service* and *medical care*. This distinction, when made, must be specifically recorded and serve as the basis for future planning. In the final analysis, there are three groups that will make that decision: the medical profession, hospital trustees, and the public. Hospital service plans have sold and will continue to sell hospital service as these groups define it. We could never reasonably expect it to be otherwise.

Our original hesitancy in endorsing the hospital service plan was due to misinformation and a *fear of health insurance,* probably inherited from our European medical ancestors, that the politician who controls the pursestrings would directly or indirectly come between the physician and his patient. We have been watching this aspect of the hospital plan very closely. While we appreciate the practical difficulties on the part of the hospital and the plan in deciding whether or not a patient, at the time of admission, will be entitled to receive the benefits of the plan, nevertheless the procedures of the hospital service plan and the hospital must be worked out so that this decision is instantly available. I realize that many persons attempt to impose on the plan by subscribing while knowing of some condition definitely or probably needing hospital care, but the physician's interest is in deciding from the medical aspect of the case whether or not hospitalization is required. He has no interest in whether or not the patient misrepresented his case to the hospital service plan, nor does he expect to have his medical decisions questioned by a representative of the hospital service plan or a hospital, or anyone other than his consultant. Any quibbling between the patient, the hospital, and the hospital service plan, at the time the physician has ordered hospitalization, as to whether or not a particular admission is covered under the plan, may operate as unwarranted interference with the speedy completion of the physician's orders. Such "three-cornered squabbles" can, and must, be eliminated if the physician and the patient are to consider a hospital service plan successfully administered.

Already the lay representative of one hospital service plan had the temerity to question my diagnosis and management of the medical treatment given one of his subscribers. Such unwarranted interference with the medical prerogatives of a physician must be guarded against by intelligent and sympathetic medical representation on the managing boards of hospital service plans. As in most things, there are two sides to this question. The hospital service plan must not in any way interfere with the prerogative of the physician in charge of the case; and physicians are more than ever bound by the concepts of professional ethics

to provide the hospital with the true record of the patient's hospitalization, but not his previous medical history. Any failure on his part to do so will make the hospital service plan powerless to protect itself against impostors, and no physician worthy of the name must stoop to collusion with such dishonest persons. If the medical profession expects its interests to be protected by representation in the managements of hospital service plans, it must adequately protect the interests of the general public who are subscribers to the plan by maintaining ethical record-keeping practice among its professional members.

HOSPITAL RECORDS

The hospital records made by hospital employees are privileged communications, but are open to hospital authorities for hospital inspection. A physician or a hospital employee who works in collusion with a patient in securing care under the hospital service plan through misrepresentation is guilty of fraudulent practice. A physician who sends a patient into the hospital for a diagnostic work-up and who makes it possible to have this covered under the hospital service plan through a false diagnosis, is not only cheating the person who subscribed to the hospital service plan in good faith, but is also depriving his medical colleagues of work which should have been done as private practice.

WARD SERVICES

A week ago I read in the New York morning paper that Dr. Goldwater, while speaking at the annual meeting of the Beekman Street Hospital Association, announced that a committee of the American Hospital Association was studying a hospital service plan which would provide ward service for its subscribers. To my mind, this is very definitely a step in the wrong direction, both from the practical financial standpoint, which I am not qualified to discuss, and from the medico-economic standpoint, which I consider my distinct province. It will encourage unwarranted and dishonest abuse of ward service. As I see it, hospitals have been placed in competition with the installment purchase program which advertising has sold the American public. The low-income group has been educated to buy everything from government bonds to grand pianos for ten dollars down. However, none of the many other groups successfully selling on installment have tried to sell their commodity for less than it cost to produce and, as a special bargain, offered to give away the time, effort, and skill of a physician who has had no voice in the matter.

Physicians have long been willing to render service without cost to patients who, they have been assured by the hospital, were financially unable to meet the costs of hospital care. Physicians giving their time in the service of ward patients must insist that hospitals do their part by limiting this service to the group who cannot afford regular semi-private service, or even the budget payment program of our Medical-Dental Service Bureau.

Ward service constitutes an expenditure of time and money to both the hospital and the physician. In the long run, it cannot be sound to encourage participation in a service which is not self-supporting. Any attempt to limit enrollment in a ward hospital service plan to a low-income group would be impractical because it could only be done fairly on an individual case budget basis, which would cost more than all the other administrative expenses of the plan. The medical profession will watch very closely, and probably with disfavor, any attempts to sell ward service on a pre-payment basis.

I realize that Dr. Goldwater's suggestion as published in the New York press is probably only an example of what he hopes can be done; however, he did mention tentatively a figure of $5.00 a year for this service. As an alternative, I would like to see serious consideration given to the methods which have already made it possible, under certain conditions in New Jersey, to provide full semi-private service under the hospital service plan for $6.00 per person per year. It seems to me that our efforts should be directed toward providing the low-income group with hospital service at

a cost it can easily meet on a pre-payment basis, and that such service be at least of semi-private level.

In closing, I would like to make it clear that while the Essex County Medical Society has endorsed the hospital service plan which was organized by our local hospitals, now known as the Hospital Service Plan of New Jersey, and has recorded its approval of the basic idea, this does not constitute a blanket approval of all hospital service plans. The degree to which they warrant our coöperation and become valuable additions to the community depends solely upon their administration. They must give full value for the payments of their subscribers. They must maintain a sound financial structure. And they must, in the interest of the patient, protect the relationship of the patient to his physician. The doctor knows that with the hospital bill paid he is also able to be paid for his services, either directly or by installments in the Medical-Dental Service Bureau. Our experience is usually bad after the patient pays his hospital bill. The Essex County Medical Society believes that these conditions exist in the Hospital Service Plan of New Jersey and so long as they do, it will receive our hearty support.

A DISCUSSION OF DR. ILL'S PAPER

By J. Douglas Colman, Director, Hospital Service Plan of New Jersey

Dr. Ill kindly made his paper available to me before the meeting, and I was fortunate in being able to prepare my discussion of it. Early in his remarks Dr. Ill alluded to an unfortunate occurrence which resulted in the division of opinion of physicians and hospitals on the desirability of the hospital service plan. In the Summer of 1935, through certain joint activities on the part of the medical profession and the hospitals, a bond of mutual confidence was established which finally made it possible for the medical profession and the hospitals to see "eye to eye" as to the desirability of actively promoting the hospital service plan. With the shoulders of both groups hard at the wheel, we will be able to produce much more rapidly the results which have proven of such great benefit to the community as well as to the hospitals and physicians caring for hospital service plan cases. This is another example of what can be done if two groups with seemingly divergent opinions are willing to approach a problem open-mindedly.

THE PHYSICIAN AND X-RAY SERVICE

In his discussion of the distinction between hospital service and medical care, Dr. Ill raised another point upon which I would like to elaborate. Perhaps if we follow through the procedure involved in taking an x-ray photograph, we will understand why a patient has difficulty in realizing that there is any element of medical service involved in this procedure. After the preliminary examination by the patient's personal physician, he is probably instructed to "go to the hospital for an x-ray". At the hospital the film is probably exposed by a technician whom the patient mistakes for a nurse. The next the patient hears of his x-ray is from his personal physician, who sagely informs him that the x-ray discloses a tumor, let us say. Nowhere in all this procedure is there any opportunity for the patient to realize that a highly skilled medical specialist interpreted that x-ray plate and supplied the treating physician with a written report of what the plate disclosed. No wonder it is hard for the patient to realize why the hospital should charge $15.00 for a single x-ray plate.

HOSPITAL SERVICE IS INEXPENSIVE

The reaction of this patient to his hospital service is, I think, a cause for concern on the part of the hospital administrators in the contemplation of their public relations program. In order to justify adequate appropriations from governmental funds, welfare federations, private contributions and the like, we have, over a period of years, built up in the public mind the idea that hospital service is expensive. Any merchandiser can tell us what poor sales psychology that is when applied to the patients who pay their bills, and after all, supply at least 60 per cent of our income. A constructive public relations program for hospitals would, in my opinion, be based on the idea that

hospitals give more dollar for dollar return for the payments of their patients than does any other vendor of service or commodities. Such a program would be designed to illustrate the tremendous stand-by capacity of sterile equipment and dressings and little-used special instruments which must be ready at a moment's notice for any kind of emergency. It would make the public realize the tremendous efforts of physicians, trustees, and administrators that make possible modern hospital service at its present remarkably low cost.

PROPER ADMITTING PROCEDURE

I was glad to have Dr. Ill take such a firm stand on the matter of non-interference by a hospital service plan at the time of a patient's admission. His attitude in this matter is absolutely correct and cannot be reasonably questioned. Whether or not a hospital service plan will provide hospital care for a specific admission cannot be the deciding factor as to whether or not the patient will be admitted. The physician's decision can be the only determining factor. Obviously then, if a patient appears at the door of a hospital with admission arranged for by a member of the hospital staff and the hospital service plan indicates to the hospital that he is a member in good standing, the hospital can do nothing but look to the hospital service plan for payment of his bill. If it should later develop that this particular patient has secured enrollment in the hospital service plan through misrepresentation of some fact of personal history, such as age or health status, it would be obviously unfair for the hospital service plan to refuse to pay the bill and place the hospital in the impossible position of attempting to collect its charges from a dishonest subscriber, probably after he had already left the hospital. This also places the physician in an unfortunate light with his patient. The only way in which a hospital service plan can equitably protect itself against such imposters is to discharge the obligation for which it is committed to the hospital and look to the subscriber for recovery of the loss on the basis of fraud or misrepresentation.

As Dr. Ill so ably pointed out, a hospital service plan will be powerless to protect itself against such misrepresentation unless the physician in charge of the case has been scrupulously accurate in his record keeping. However, handled in this way, the problem of protecting the hospital service plan from impostors becomes limited to a discussion between the subscriber and the plan. The hospital and physician are relieved of all responsibility in the matter and all interference with the physician's decision as to the need for hospital care is eliminated.

WARD SERVICE UNDER THE HOSPITAL SERVICE PLAN

I was glad that Dr. Ill questioned the desirability of ward service under the hospital service plan. I feel, as he does, that this is fundamentally unsound. Naturally he has approached that conclusion from the standpoint of a physician's interest. I, too, can see no practical way in which the physician's interests would be adequately protected through any attempt to limit the sale of such service to a particular income group. However, my conclusion that such a program is fundamentally unsound is reached on an entirely different basis.

Our experience in Essex County during the past four years leads us to believe that, if a hospital service plan is relieved of the financial drain imposed by subscribers who receive hospital care through misrepresentation, the actual cost of semi-private hospital care alone for a group of subscribers who join in normal health is somewhere in the neighborhood of $4 or $5 per subscriber per year. This being true, the only additional cost to the subscriber is that of administration. Two things will operate to keep this at a minimum: First, efficient management, and second, simplicity. There is nothing complicated about the hospital service plan idea. Groups of people make joint payments to provide for the cost of hospital care of those members of the group who need it. If hospital service plans have the ability and will power to sell that simple idea without adding the sales "gadgets" that may seem, for the moment, to be demanded by the public, the administrative cost can be kept at an absolute minimum. Nor will there be any

difficulty in providing the low-income group full semi-private care at a charge it can afford. However, to do this requires a singleness of purpose on the part of the medical profession, the hospitals and their Trustees, and, most important of all, employers.

If a ward hospital service plan were to pay the hospitals $4 a day instead of the usual $6 for semi-private care, the cost for hospital care per subscriber per year would be reduced by one-third. If this cost is normally $4 per subscriber per year, it would be reduced to $2.67. To this must be added exactly the same administrative cost as for a semi-private service plan, which, for argument's sake, let us say averages $1.50 per subscriber per year over a large volume of subscribers. Thus the irreducible minimum annual cost of a ward hospital service plan is somewhere in the neighborhood of $4.17 without including any allocation for reserve which would probably bring it up to $5 per year. Already we are supplying full semi-private service to certain groups of employed persons for $6 a year in Essex County, and for their families at an average rate of $5.50 per person. I submit to you, therefore, that the difference in cost between a properly administered hospital service plan supplying semi-private service and one supplying ward service is so small that it does not constitute the factor which determines how large a proportion of the general community will protect itself under the hospital service plan. That is determined by the efficiency of its management and the degree of united support received from the hospitals, the medical profession and the employers of the community. Without such support nothing is possible.

THE MEDICAL-DENTAL BUREAU AND HOSPITALIZATION INSURANCE

By Harry H. Satchwell M.D.

Chairman, Medical Education Committee, Medical Society of New Jersey

Read before the New Jersey Hospital Association in Newark, January 27, 1937.

This is the first opportunity that has been offered for the major participants in the Bureau—the physicians and the hospitals—to meet together as a group. The telling of the story, which is new to some of you, cannot help but bring a better understanding to the rest of us who work together every day.

You know, the creation of this organization was not quite as spontaneous as it must have seemed when we first laid the plan before your somewhat startled eyes. For a long time the medical profession has had an academic interest in bettering the distribution of medical service. I say academic, because seven and eight years ago doctors' incomes were, on the whole, satisfactory, and the men could afford to do a lot of work *gratis* without bothering to count up its real cost. Better distribution was then mainly a matter of increasing the number of services that were offered without cost.

Then came the late, unlamented depression. Not only did incomes drop but doctors found a lot of their practice slipping away because old patients could not pay, and were ashamed, or afraid, to request further treatment from their own physicians under these circumstances. Loss of income and failure to reach a great many of their patients provided much of the incentive needed to make the profession sit down and think about practical ways to overcome the trouble.

The rest of the incentive needed was also depression-born. It was the increasingly apparent determination of the government to see that health services were made available to all classes. A program for indigents came first and we in New Jersey have probably had as much experience with this program as any group or state in the country. We believe the plan as conducted in this State was one of

the best instituted anywhere; and we endorse the principle of using tax funds for the provision of such services to the totally indigent. It also became evident, however, that some public officials considered government responsibility for the health of the *indigent* only the first step toward the assumption of responsibility for the health of *everyone* regardless of his economic status.

Please do not misunderstand me. I am not trying to tell you that the program we have worked out thus far within the confines of this county is going to put a quietus on all the national agitation for the socialization of medicine. I do believe, though, that the sum total of all these constructive efforts, despite the fact that they are prompted by the threat of governmental control of the entire health field, is going to give us arguments for handling the problem as we think it should be handled. In short, we recognize that the distribution of health services must be improved and adapted to meet current conditions; but if there is any *socialization* to be done, we intend to do it ourselves from within the profession.

To be specific, we have formed the Medical-Dental Service Bureau. This is simply a nonprofit, corporate enterprise under the exclusive control of the physicians, dentists and hospitals whose purpose it is to see that responsible people in the moderate income group are given a reasonable opportunity to pay reasonable charges for health services.

Our entire population can be divided into three general groups—1, the indigent; 2, the middle class; 3, the well-to-do. The Bureau is not concerned with indigents, because the entire cost of their care must be met by someone other than the patient and the Bureau has no such resources. Neither is it concerned with the well-to-do because they have the cash to pay for whatever they want. *We are interested solely in that large middle-class group which can and will pay for anything reasonable,—on the installment basis.*

Remember this: The hospitals and the doctors must compete with the refrigerator salesman, the automobile salesman, and every department store for a share of the consumer dollar. And you can't compete by shoving a $85 hospital bill under the patient's nose and demanding payment in full within twenty-four hours when everyone else with anything to sell is shouting "no down payment and only fifty cents a week".

ADMISSION OF A PATIENT

Getting back to the actual functioning of the Bureau. It is a business office to which physicians can refer patients diagnosed as needing service that is beyond their ability to pay in full immediately. And when I say pay in full, I mean the total bill as seen from the patient's viewpoint, including both the hospital *and* the doctor bill. A member of the Bureau staff sits down with the patient and obtains information (verified, of course) which results in one of the three following decisions:

1. That the patient can pay the regular hospital charge and doctors' fees if given the opportunity to spread these costs over a period not exceeding ten or twelve months.

2. That the patient can pay regular hospital charges and an *adjusted* doctor's fee if given the opportunity to spread these costs over a period not exceeding ten or twelve months.

3. That the patient can pay no more than the minimum hospital charges (ward rates) even if deferred payments are arranged.

Do you see what this means in actual practice? The patient is referred *by the doctor before* admission to the hospital. It means that the doctors have recognized one of their own weaknesses which has given gray hair to many a hospital admitting clerk and superintendent, —the practice of ordering a patient admitted to semi-private accommodations without anyone having the least idea of whether or not he can pay for such accommodations.

Also note that in none of the three possible decisions is the hospital requested to modify its regular charges. The doctor may have to modify his fee or forego it entirely; but this is not so with the hospital. The Bureau's only interest in the hospital is to put the patient in semi-private accommodations if he can pay for them, or in ward accommodations if he cannot.

PAYMENTS BY THE PATIENT

The next step taken by the Bureau is the arrangement for payments by the patient. As much as possible is secured immediately, and the anticipated balance is budgeted in weekly or monthly installments according to the needs in each case. These arrangements are, of course, approved by the doctors and hospitals involved; and copies of the agreement are sent to each.

ALLOCATION OF PAYMENTS

All payments made by the patient are made to the Bureau, and these payments are prorated between the doctors and the hospitals according to the size of their bills. The total amount of business written and the disbursements made during the year show that the hospitals have actually received a little more than their pro-rata share.

Once each month the Bureau sends to each professional member an itemized statement of the payments made by patients in which the doctor or hospital is interested and a check of 90 per cent of the payments so made. The balance of 10 per cent is retained by the Bureau to cover its operating cost.

The Medical Society feels that the Medical-Dental Service Bureau is doing more than helping to meet the threat of outside control of the entire practice of medicine. It is helping the profession set its own house in order in the matter of reasonable charges; and it is also making the doctors and the hospitals realize they are complementary parts of the same health service. We used to feel that it was our job to look out for our own interests and get all we could out of the patient, because we knew the hospital was doing the same. Let me give you a few figures to show what the results of coöperation have been.

During its first year of operation the Bureau budgeted nearly 3000 cases. Total business written amounted to $143,267, of which $68,854 was for physicians' services; $9868 for dentists' services; and $64,544 for hospital care. Disbursements by the Bureau during the same period were $27,801 for physicians; $5302 to dentists; and $28,294 to hospitals.

CO-OPERATION

Frankly, it is going to take a long time to persuade all the physicians in the county to make the concessions demanded if the principles of the Bureau are to be carried out completely. I believe the figures show, however, that the Medical Society has achieved a real success in a relatively short time. The value of the Bureau has been definitely shown, and the Society has every reason to count upon the continued active coöperation of the hospitals in this mutual problem of providing health services to the moderate income group.

From these comments, it must be obvious that the Bureau and the Hospital Service Plan work together in complete accord. We physicians like the plan for the benefits it brings to the patient, and for the benefits to the Bureau in having to budget smaller bills. Although the membership of the Service Plan is growing rapidly, we cannot expect to see it grow big enough to be everybody's answer to hospital bills. Reaching any considerable proportion of the approximately four million people of this state, or even of the 800,000 in Essex County alone, is a Herculean sales job. But as the plan grows, we work with it hand in glove because we consider that the plan and the Bureau are complementary organizations.

NURSE EDUCATION AND TRAINING FOR THE CARE OF THE SICK

By A. Charles Zehnder, M.D.,
Chairman, Committee on Nursing, Medical Society of New Jersey

The Committee on Nursing and Nursing Education of the New Jersey State Medical Society, of which I am Chairman, highly approves of the courses of nursing education given at present in several of the colleges in this country; for thereby nurses will be educated in such a manner that they will be prepared to do teaching in the training schools. We also are of the opinion that the pre-nursing education should be of as high a standard and quality as the nursing profession desires. In regards to the system in which this group of nurses acquire their professional education, we feel that this could be satisfactorily arranged; but the cost should not be the financial burden of the hospital, as it is at present, thereby directly placing the cost upon the hospital patient, who already is overburdened with the high cost of hospitalization.

We think it advisable that *the present system should be changed as to the time spent by the pupil nurse at the bedside.* At the present time this has become less and less. We are therefore *in favor of a period of preparation* for nurses in *didactic school work, at which time they shall not do nursing service in a hospital;* to be followed by a period of uninterrupted bedside instruction in nursing care in the hospital. (We are not indicating where this should be done.)

In planning this system of nursing education many factors will have to be considered, the first of which is the *quality;* the second, the *cost and method;* the third, *where given.* In changing our present system, many of the above-mentioned factors will have to be considered, and possibly some cannot be changed very quickly; but we should keep them in mind as an objective in planning for the education of the graduate nurse.

QUALITY OF EDUCATION

The first consideration of nursing education should be *quality;* and that this is not of the highest standard at present is well shown by the report of the Committee for Revising the Curriculum of the Three National Nursing Associations, in which they state, "The Grading Committee's findings revealed that the majority of nursing schools in the country are mediocre schools, and that there is no need for more graduate nurses with mediocre training and background."

COST OF EDUCATION

The next consideration should be the cost; and this varies so that at present it is doubtful whether the great majority of training schools really know their cost. There are nine factors to be considered in establishing the actual cost. This factor is well shown by Miss E. Muriel Anscombe's article in the Modern Hospital of November, 1936.

In the new curriculum now being presented to the training schools, students will give fewer hours of work in the wards and this will therefore increase the cost to the hospital.

Finally, should not the problem of educating nurses be in the control of educators trained solely for this purpose?

THE NURSING ATTENDANT

There is a definite field for a nursing attendant to minister to the physical wants of the mildly sick; the post-operative home patient; the mother and new-born infant; and the patient who is not seriously ill. To supply this need, women between the ages of twenty-one and forty-five years of age who have a minimum of a grammar school education should be trained.

This special field of nursing should include simple nursing procedure, plain house work, economical buying of food, cooking, and care of the well child. In other words, in addition to caring for the patient, the nursing attendant should be *trained to manage a home in which there is no servant or very little service.*

The training should consist of one year of training in a small hospital in which there is

no training school; to be supervised and trained by a graduate nurse; and six months' supervision while doing private nursing in the home.

The fundamental training should teach simple nursing procedure; cooking; plain house work; and care of the well child.

The cost should be $18 to $21 per week.

The nursing attendant should be registered and licensed by the State, and thereby be given a definite standing and qualification to do the work for which she is trained.

We do not believe that the number of practical nurses should be increased; but we feel that this problem cannot be controlled unless we develop a nursing attendant *to deliver that quality of nursing which is necessary in the home, but does not require the ability of a graduate registered nurse.*

We believe that the medical profession should be represented on the Committee of the National League of Nursing Education, which arranges the curriculum for the training schools, so as to coöperate in preparing this important matter. The reason for this is that considerable of the teaching given is by the doctors, who at present are not represented on this committee.

Our committee is very anxious to coöperate with the nursing associations.

DISCUSSION OF DR. ZEHNDER'S PAPER—No. 1

By Margaret Ashmun, R.N., Director of Nursing, Orange Memorial Hospital; President, New Jersey State Nurses Association

Abstract of a paper presented before the New Jersey Hospital Association in Newark, January 27, 1937.

It is not new in New Jersey for the Hospital Association and the Nurses Organization to discuss their problems in joint meeting, but it is an innovation for the nursing organization to have a part on a program of the State Medical Society.

No one of us will disagree with Dr. Zehnder's statement that there is a definite use for the trained subsidiary worker, attendant, or aid, providing the recommendations of the Curriculum Committee of the National League of Nursing Education are met by all the schools of nursing in the country.

Nurses have worked side by side with these subsidiaries ever since schools of nursing were established, and perhaps we are responsible to some extent for their increasing need; for as the demands of medical science have progressed, nurses have been obliged to concentrate on technical skills and leave the kitchen, so to speak, to someone less highly trained.

It is generally considered a good procedure, where a new school of any kind is recommended, to have the first step a study of present conditions, needs, and opportunities for employment for the products of such a school. Dr. Zehnder does not feel that the number of subsidiary workers needs to be increased. If that is the case, it might be well, before suggesting courses which will place a large group of these people in the community, to find out just how many men and women, not registered nurses, are doing some kind of nursing for hire; to learn just what preparation they have had to do this work.

A committee of the American Nurses Association, the National League of Nursing Education, and the National Organization for Public Health Nursing, is at present occupied in a study of this subject, and the State organizations are also forming committees to further the work of the National.

In Essex County the Girls' Vocational School is contemplating such a course for training attendants. It is interesting to note that they cannot offer a course called "domestic aids" or "housekeeping aids" because no one will sign up for it. They must inject the word "nurse" if the course is to be a drawing-card. This course will not be under the auspices of the nursing organization; but we, as well as you, are to be invited to act in an advisory capacity.

It is important therefore that the vocational school experiment should go slowly and that the rest of the State be content to watch it materialize, observing its progress and success (?) before "courses" are permitted to spring up like mushrooms.

In Essex County also the nurses of the Dis-

trict Association (a division somewhat similar to your County Medical Society) are working toward the establishment of an Official Community Nursing Bureau for the county, and if we are not mistaken, your County Society has already been invited to sit on an Advisory Council with hospital administrators, lay members, and nurses, to study the need and desirability of such a bureau.

We do not pretend to have covered in this short discussion the problem in relation to the rural communities. We recognize that this is a different angle and will undoubtedly be considered by the official committee now studying the whole, and prefer not to go into it until we have a report from them.

When we try to discuss the education of the student, it is necessary to hold on tight to the conference table in order to prevent open battle.

Much of the prerequisite education *for* nursing could be given before a student is admitted to the hospital. This is a sound principle, and we have been thinking along these lines for years. It has real possibilities and many problems; but we do not feel that a student nurse can get a proper education *in* nursing unless most of her course goes hand in hand with her laboratory work (hospital wards).

We know there are solutions in part to this problem. Sufficient graduate staff to carry the responsibility and maintain an unbroken routine, and a block system of classes whereby students will have a month to six weeks in the class-room followed by a 12-14 weeks' straight ward service and then repeated, are a great help. This requires an increase of staff nurses, an expense which most hospitals are not prepared to meet because they find student service a necessary economy.

When it begins to cost more to have a school than to do without it, only then will it be actually a "financial burden". If our schools are to prepare nurses to meet the demands of the present day, financial assistance must be found. Medical schools, teachers' colleges, and other professional schools have endowments, State funds, and tuition to aid in their support. Few nursing schools have *any* resources. This is the reason why doctors receive no remuneration for their lectures, a fact which we deplore.

The Central Curriculum Committee has had as consultants members of these same organizations plus qualified educators from many fields. In all the states last year there were formed study groups organized for criticism and suggestion on this revision. Many individual physicians and others were invited to help in this study, but so far as we know in New Jersey, the Medical Society was not asked to send representatives. We realize that this was a grave oversight.

Few of the schools in New Jersey at the present time are even giving a minimum education in many essential nursing services. They cannot meet, nor will they be expected to meet, the maximum in even a year or two, but if their graduates of tomorrow expect to have a place in community nursing as we see it, these schools will want to inaugurate step by step the proposed improvements, or they will find the right kind of student going elsewhere.

At the risk of being run out, may we suggest that if you really want to help in the nursing educational program of this State, you start with a careful study of your own schools. Compare what they are now doing with what is recommended that they should do; not just a judgment based on personal ideas of yours, but based on sound study. Support them wholeheartedly in plans for financial assistance to enable them to progress, and yet remove the burden from the cost of hospitalization.

DISCUSSION OF DR. ZEHNDER'S PAPER—No. 2

By Edgar C. Hayhow, Superintendent, Paterson General Hospital; President, New Jersey Hospital Association

Abstract of an address before the New Jersey Hospital Association January 27, 1937, in Newark.

A passing review of the field of medicine clearly shows the marked changes in medicine. Apparently medicine is not the only profession which seems to be undergoing this process of metamorphises. The time in preparation; the pre-medical course; the university connection; the hospital "tie-up"; the internship; the Board of Licensure—show this constant effort for a more standardized procedure towards a more qualitative finished product.

We can see at a glance the different concepts, the different points of view, between the change in the field of medicine and the proposed changes in the field of nursing. Medicine is a primary or a basic profession.

The field of nursing comes into an entirely different classification. Its basic conception was an auxiliary service. It has always, is, and I think—insofar as patient nursing—always will be. It is not a component part of medicine; it is adjunct to it.

I contend that the major difficulty with our nurse educational program is that there has been no coördination between the secondary school and the nursing school. The secondary school, on the one hand, has "herded" its student body into one large mass which, "speaking for the nursing group", wakes up one morning and finds itself enrolled as members in individual Schools of Nursing. No orientation; no preparation; no nothing. And then we find fault with the misfits and brand the whole batch as misfits.

And then came the wave of this thing called "higher learning". Immediately the university affiliation became the mode. All courses were made a part of the college curriculum. And so, why not nursing, perhaps?

My contention is that as soon as a few affiliated courses started everybody wanted "to keep up with the Joneses". Educationally, I agree that for the first time these university schools did have a standard preparation with a standard prerequisite for a standard course. Priorly, girls with one year high school sat beside girls with Master's Degrees. That is poor education for both.

Society in general and hospitals in particular need to educate women for "general duty" work. The physician demands a certain type of nursing service that does not require a too elaborate educational background at a cost within the limits of society's ability to pay. This suggestion is not new; physicians and nurses alike appreciate its advantages and its limitations. It also seems logical to assign many routine duties of the bedside to an attendant group. This group is now "nursing" in the community, and should be appropriately registered under State authority. However, short courses of six months to one year could be established in recognized and approved hospitals for this group. Upon the satisfactory completion of this course in the simple rudiments of nursing procedure, by examination, the applicants could be duly registered. As there is need for some of these nurses educated on a higher level, so is there need for nurses with a lower level of training to equalize the load. Potential remuneration for grade levels should be in keeping with educational levels.

The same thought can be carried to the attendant service. Nurse leaders are aware of its desirability and again of its pitfalls. But really, some of these pitfalls could already be covered with the paper upon which such services have been suggested by various groups.

Don't let's confuse our thinking too much by making a pot pourri of all these subjects from the approach of these various points of view, and then mix costs, social integrations, state medicine, socialization, the humanities, as mere condiments for our delectable delicacy and served as an example of the ideal nursing curriculum. There are no panaceas,—as yet.

I appreciate Dr. Zehnder's point of view and approach. I appreciate Miss Ashmun's point of view and approach. I have had enough dealings with both groups to know they appreciate the State hospitals' point of view and approach. The fact that each group is here is a move in the right direction.

SOCIAL SECURITY AND HOSPITAL RELATIONSHIPS

By Thomas K. Lewis, M.D.
Chairman, Medical Practice Committee, Medical Society of New Jersey
Read before the New Jersey Hospital Association on January 27, 1937, in Newark.

The Social Security Act may be divided sharply into two portions; the first, providing special care, through Federal funds, for various classes of unemployable indigents; and the second, providing against old age and unemployment in the future for the employed.

The first portion, which allocates to the various States money grants for special services to the blind, to crippled children, to orphans, for Maternal and Child Welfare, for extension of public health activities, etc., has already been in operation for six months or more. In the application of the provisions of this Act, our State Legislators have turned over to the State Medical Society, in conjunction with the State Department of Health, supervision in all fields where medical service is implicated. In the use of these Federal funds the State Society has held constantly in mind two basic considerations,—(1) the best service to the unemployables involved; and (2) protection and assistance to the practitioner of medicine.

SERVICE TO UNEMPLOYABLES

With the first principle in mind, we have held unswervingly, often with considerable opposition by Federal authorities, to the proposition that *no tested and time-proven institution already in operation within our State should be disrupted or distorted.* As an example of this, we point with pride to our Crippled Children's Commission, which stands out preeminently as the finest service of the sort in the whole nation, and which has served as a pattern for the organization of similar set-ups in a large number of our sister states. We have made certain that the use of Federal funds for crippled children shall further, but in no way detract from, the efficiency of present operation. The gentlemen of this Commission, mostly lay persons, boast of the fact, and with justice, that no crippled child of the under-privileged class within our State need grow into adult life without adequate medical service and supervision.

ASSISTANCE TO THE FAMILY DOCTOR

In consideration of the second principle, protection of and assistance to the general practitioner, we point to the activities under the headings of Public Health and Maternal and Child Welfare. Our stubborn battle for this principle arises from firm conviction in, and concurrence with, the statement of the leading minority report of the Committee on the Cost of Medical Care that *the family doctor is the cornerstone of the whole structure of medical service in America,* and is fundamentally essential to the peculiar needs of our people. In any discussion of economics, one must keep clearly in mind the fact that the great mass in America is composed of *middle-class persons,* whereas, in Europe, the great mass is made up of *peasants* who, in habits and in mode of thought, are little above the state of serfdom.

SPECIAL PREVENTIVE SERVICES

Under Public Health supervision, there will be further support of the Public Health Hour plan of Dr. Stanley Nichols, which as you probably know, has been instituted for the purpose of stimulating greater interest in preventive medicine on the part of the family doctor, and making much service locally and readily accessable to all kinds and all classes. Through this plan the doctor can afford to render such service free, or for a very low fee.

In handling the special service for Maternal and Child Welfare the Federal authorities were strongly in favor of full-time social workers and obstetricians to tour the State and attempt to teach doctors and patients. The State Medical Society objected to this proposition on the grounds that it would not reach the spots where help was most needed; and that the caliber of the obstetrician who would give up private practice for a not too liberally paid position of uncertain future would, to say the least, be questionable.

The *indigents* are receiving fairly satisfac-

tory attention through our hospitals. The greater need at the moment is for support of the doctor in caring for the maternity case in the *low-wage group,* where wretched nursing care is the rule; where low pay makes pre-natal and post-natal care burdensome; and where monetary considerations preclude consultations in difficult cases, often with disastrous results. Therefore, to assist both physician and patient, the following services are being provided through Social Security funds:

1. Lecture courses in obstetrics for the general practitioner by competent specialists.
2. Part-time field physicians of recognized ability, whose duty it is to visit physicians practicing private home obstetrics; and not only explain the services available, but urge attendance to lectures and to outline the rules which have been established for the purpose of reducing maternal and infant mortality.
3. The establishment of pre-natal clinics where the low-pay patients can receive the proper attention, if the attending physician so wishes. These are to be established particularly in the rural and more backward areas.
4. Through the nursing organization a special service for the delivery, for which the nurse is paid a special fee but of Social Security money.
5. Consultation service, whereby a specialist may be called with no cost to the low-wage family.

COMPULSORY SICKNESS INSURANCE

At the moment, the second portion of the Social Security Act does not intimately concern us, except for the fact that up to date no one has been willing to assume the responsibility of deciding whether or not hospital employees are subject to the provisions of the Act. However, it is quite possible that in the not distant future compulsory sickness insurance will be supplemented. Labor and certain socialistic forces are bent upon such a program; and in spite of the fact that the President has expressed his disapproval, it is not unlikely that a sickness insurance amendment will be appended to the existing act.

Should this happen, it is of utmost importance that all branches of the healing art and all institutions connected with the practice of medicine unite in a spirit of teamwork, and strive for the best interests of the American people. Special interest should be subjugated to the greater interest of the whole. Bureaus, departments, and institutions will be, and have been, much attracted by this plan, because they deal with the practice of medicine as a mass problem. Hospitals, surgeons, and other specialists will undoubtedly be the gainers by the adoption of compulsory sickness insurance, because there will be some financial return for much of the work that is now being given as a charity. However, the general practitioner will have his income immeasurably reduced, and his work tremendously increased. In considering this problem, please bear in mind the fact that the medical service rendered in hospitals, important as it is, after all represents less than one per cent of the medical care received by the American public. (I refer you to the data furnished in the report of the Committee on the Cost of Medical Care, which is summed up as follows: two per cent of the population is ill at a given time, 50 per cent of this illness is very minor; and only five per cent of the two per cent illness is catastrophic.)

It is vastly more important *to keep well* than it is to receive the highest grade of medical care when seized with some hopelessly incurable disease. A prompt diagnosis of an acute appendicitis, plus a mediocre surgeon, is much to be preferred to a tardy trip to the hospital plus perfect equipment and the most illustrious surgeon. Without an early diagnosis of cancer of the cervix, radium and surgical care of the best is of no avail. Proper treatment of the first attack of rheumatic fever and endocarditis, with careful supervision of the activities and training of the growing child with cardiac disease, is the important factor,—not the finest care in an institution when premature cardiac breakdown from irreparable damage has appeared.

THE FAMILY DOCTOR

Whether this nation keeps well, whether morbidity and mortality rates are lowered, and whether we can breed a hardier race, rests not with institutions, but with the efficiency and

integrity of the general practitioner,—*the family doctor*. It is for this reason that one of the chief efforts of organized medicine in recent years has been to reëstablish that important institution, *the Family Doctor,* which has been rapidly vanishing, particularly in the metropolitan districts. It is for this reason that we desire, not greater *concentration* of medical service, but rather a greater *diffusion* of that service.

I wonder how many of you assembled here, largely concerned with the operation and management of hospitals, are aware of the part played by the *family physician* in every-day American life. A large percentage of the patients he treats are not suffering from classic disease, but are complaining of symptoms,—mental and physical,—which have their origin in socio-economic imbalance. Such individuals need moral support, sympathetic advice, and perhaps some medication, in order to enable them to carry on with the obligations of life in the face of insuperable difficulties.

The activities of the family doctor are legion. He must be all things to all people. He is a father confessor. He must often arbitrate marital misunderstandings. He is consulted for behavior problems of children. He is consulted about educational problems. He is called upon to help in saving a home, or in sending a boy to college. I could tell you innumerable tales gleaned from twenty some years in practice about the deeds of the family doctors of my community that would seem like the ravings of an opium smoker. They have done everything from washing babies and changing diapers, to chopping wood and washing dishes when the need arises.

You will probably be thinking that all doctors are not of this breed. Almost every family has its black sheep, and I suspect that every profession has its misfits. Those of us who were involved in the recent Emergency Relief experiment are well aware of the fact that in our ranks there are some chiselers, and there is some dishonesty; but I emerged from my duties on the E. R. A. coördinating committee with a very high opinion of the other 98 per cent of medical men of my county, and that, I am positive, is the consensus of opinion on a State-wide basis of those similarly placed.

The family that puts itself in the hands of right sort of family physician, generally speaking, can be assured of getting the best kind of medical service available in that community, whether he be a full pay, part pay, or charity patient. The loyal use of such a family physician, carefully selected, *is the best form of sickness insurance the low-income family can possibly have.* The average physician, looking back over a number of years during which a family has been the source of steady income (ten, twenty, thirty or forty dollars per year), is not particularly disturbed when he is called upon to treat a case of serious illness with small or delayed monetary returns.

This leaves only surgical catastrophies to be covered, and these can be met by a combination of *hospitalization insurance* and a *Medical-Dental Bureau* such as exists here in Newark and in several other New Jersey cities.

In concluding, I would stress this one point: If, in the months to come, we are called upon to participate in any form of socialization of medicine, for the best interest of all concerned, let *protection of the general practitioner* be the lodestone toward which our united efforts shall be directed.

DISCUSSION: SOCIAL SECURITY AND HOSPITAL RELATIONSHIPS

By F. Stanley Howe, A.B., Director, Orange Memorial Hospital

Read before the New Jersey Hospital Association, January 27, 1937, in Newark.

The developments of modern medicine and surgery have done much to bring doctor and hospital closer together,—a trend which will certainly be accelerated in the future. In meeting the problems now facing the medical profession, the coöperation of the hospitals would seem to be essential.

CARE OF INDIGENTS

Social Security legistlation will inevitably provide funds for medical care of indigents and pensioners, which were not heretofore available. It is unlikely, however, that such funds will be large. It is, therefore, the duty of society to use them with the utmost econ-

omy and efficiency; and in their distribution every effort should be made to see that they reach the type of doctor who will give the very highest form of service to recipients. Any looseness which permits the wasting of money for unnecessary calls will inevitably cause a reaction in the public mind against the medical profession as a whole, and will deprive the better men in the profession of their fair share of reimbursement for the services which they may render.

COMPENSATION OF HOSPITAL AND CLINIC DOCTORS

For some reason, public officials have adopted the attitude that physicians serving on the staffs of hospitals and treating charity patients in either wards or clinics should not be compensated, though they seem to have no reluctance to pay reasonable fees for services rendered in private offices. Abundant evidence is available that this system has been greatly abused. Relief officials are fully aware of this abuse, but appear to be powerless to prevent it. Their antagonism will go far toward discrediting such a method, and ultimately developing an acceptable substitute. In many discussions with physicians the following facts seem to be very clear:

First, the high-grade and reputable physician with a good private practice cannot afford to handle the relief client in his private office, both on account of the effect upon private patients, as well as the large amount of paper work required. Such men, however, are glad to give their best service to the relief cases in connection with their ward and clinic work in charitable hospitals. The better type of physician, both professionally and ethically, is almost invariably to be found on the staffs of approved hospitals, through which service he makes his contribution to the welfare of society. For physicians not on the staffs of charitable hospitals to claim any great amount of "free service" in the best sense, is absurd. In the hospital clinic, patients are not seen more often than necessary to give them adequate care. They are, furthermore, referred to appropriate clinics where their conditions will be treated by men specially trained to give them service indicated. These factors make for the highest type and minimum amount of attention necessary for each individual case; and result, therefore, in the greatest benefit to society at the least expense.

The suggestion which I have already discussed with many men, and with some relief officials, is that indigent patients applying to them for medical care should be referred to the nearest approved *Out-Patient Department;* and that a fee of only fifty cents be paid by the public for each medical examination or treatment by a physician on the *clinic* staff, this fee to be in addition to a reasonable payment for the *hospital* service involved. For example, a charge of $1.00, which is now paid for office visits, would be made by the hospital, and the other half placed in a fund to be distributed on an equitable basis among the members of the clinic staff. Such a method would remove temptation from individual physicians either to hold cases in their clinics which should be referred, or to suggest needless visits.

In his treatment, the physician would have the nursing and clerical force of the clinic at his disposal, relieving him of the expense and bother of *record-keeping,* and the accounting necessitated by this type of work. It would seem probable that his net return would be greater than if he were to see the patients in his office at $1 a visit, and he would be spared the intrusion of such patients into his limited office hours.

HOUSE CALLS

The problem of house calls might be met by some such plan as to have the City Physician make the first call; and if he felt that further care was necessary, refer the case to the nearest approved clinic, through which the patient would be assigned in rotation, or for geographical reasons, to some member of its staff,—all records of calls made at the house to be entered on an Out-Patient chart, and kept on file at the hospital.

NEWER METHODS IN THE DIAGNOSIS AND PREVENTION OF WHOOPING COUGH

By George F. Leonard, M.D., New Brunswick, N. J.
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Read before the meeting of New Jersey Health and Sanitary Association at New Brunswick, N. J., November 20, 1936.

Whooping cough is one of the communicable diseases that has always been difficult to control. It has a world-wide distribution and is endemic almost everywhere. It also occurs in epidemics which vary greatly in virulence, extent and mortality. The annual peak of the disease occurs in the early spring months, and there is a tendency to a secondary rise during July and August, with the last three months of the year uniformly low. It may be of interest to note that 80 per cent of all cases are under five years of age.

The mortality for whooping cough is higher than for measles, scarlet fever or diphtheria. Whooping cough is especially severe in the young, 78 per cent of the deaths occurring during the first two years, and 97 per cent during the first five years of life. These facts must be taken into consideration if a systematic effort is undertaken by physicians and health officers to control the incidence and to reduce the mortality.

ETIOLOGY

The causative organism of whooping cough was isolated and described by Bordet in 1900. In 1906 Bordet and Gengou [1] successfully cultivated it on artificial media. After considerable controversy as to whether a filterable virus played a part in the etiology, the Bordet-Gengou bacillus, now called *Hemophilus pertussis,* has practically been accepted as the real cause of whooping cough.

One of the reasons why whooping cough has been difficult to control is because it is most contagious during the early catarrhal stage before diagnosis is made. Therefore, early diagnosis is necessary for a feasible method of whooping cough control.

DIAGNOSIS

Chievitz and Meyer [2] in 1916 first used the cough plate culture method and found that a high percentage of their cultures were positive for *H. pertussis* during the early catarrhal stage. This method of diagnosis apparently received little attention until 1925, when Madsen [3] published the results of 914 cases of whooping cough in which he used the cough plate culture method, and demonstrated 75 per cent positive for *H. pertussis* during the catarrhal stage of the disease. In the interval from 1916 to 1926, the Serum Institute at Copenhagen made 7695 *cough plate diagnosis* for whooping cough. Then came reports in rapid succession from a number of workers who had successfully used the cough plate, Lawson and Mueller,[4] Sauer and Hambrecht,[5] Gardner and Leslie,[6] Macdonald and Macdonald,[7] Kendrick and Eldering,[8] and many others. The cough-plate method has been used so successfully by many different workers that it is now considered a thoroughly reliable method for the early diagnosis of whooping cough.

A committee of the American Public Health Association on methods and reagents for the diagnosis and control of whooping cough has reported tentative methods for the bacteriological diagnosis and control of whooping cough.

COUGH PLATE MEDIUM

The cough plate as recommended by this committee is prepared with a slight modification of Bordet and Gengou's potato blood agar.

Five hundred grams potato, freshly peeled and sliced, to which is added 40 cc. U. S. P. glycerine, and 1000 cc. of distilled water, are boiled in a covered kettle until soft. The contents are made up to original volume, strained through gauze, allowed to stand for sedimentation, and the supernatant liquid is siphoned off.

To 500 cc. of the clear potato extract is added 1500 cc. of 0.75 per cent sodium chloride, 60 grams bacto agar, and 20 grams proteose peptone. It is heated until the agar and pep-

tone are dissolved, dispensed in flasks suitable for storage, and autoclaved for twenty to thirty minutes at fifteen pounds pressure.

When ready to use, a flask of the base is melted in a water bath or Arnold, cooled to 45° C.; and fresh blood, which has been previously heated to 45° C. is added to make a final concentration of at least 15 per cent. The blood should be fresh, never more than seventy-two hours after it has been obtained. It may be from cow, sheep, horse or human source, but avoidance of horse blood for the vaccine medium is recommended. The blood is mixed with the base by whirling to avoid air bubbles, and poured aseptically into Petri dishes, about 15 cc. per plate. Satisfactory plates should be bright cherry red in color, and free from bubbles and lumps of agar. One or more plates from each lot should be incubated for twenty-four hours at 37° C. to determine sterility. One plate should be inoculated with *H. pertussis* culture to check growth, colony appearance, and characteristic hemolytic zone. Plates may be used as long as they remain moist and red,—usually two or three weeks if kept in a refrigerator.

TECHNIC OF TAKING COUGH PLATES

It is best to give the child a drink of water before taking the culture, as this tends to diminish the contaminants. Hold the uncovered plate three to four inches from the patient's mouth during one or more spasms of coughing. It is best to expose two plates to each patient. Avoid dripping of saliva into plate, as this usually causes spreaders. It may be necessary to induce cough by means of a tongue depressor, by tickling the throat with a swab or by pressing on the larynx. Cover the plates as soon as possible, and place them in an incubator at 37° C.

EXAMINATION OF PLATES

Examine the plates several times during the first forty-eight hours for molds or other spreading colonies which might overgrow the plates, and cut these out with a sterile needle or scalpel. After forty-eight hours, search for colonies of *H. pertussis,* using a hand lense or a colony microscope. The plates may be examined by transmitted light if the culture media is not too thick, by placing the uncovered plate over an ordinary substage lamp. The thicker plates may be examined by reflected light by tilting the uncovered plate in front of the light which comes from one side. The plates should be examined daily until *H. pertussis* is found, or until the sixth day, when they may be discarded.

IDENTIFICATION

The colonies of *H. pertussis* appear smooth, raised, glistening, pearly, and almost transparent. They are surrounded by a characteristic zone of hemolysis, which is not sharply outlined but merges somewhat diffusely into the surrounding medium. The colonies of gram positive cocci in general appear duller, darkly colored, and opaque. In the early stages of whooping cough, the colonies of *H. pertussis* are quite numerous. With a little experience, it is fairly easy to be able to make a diagnosis from the appearance of the colony.

In stained smears by Gram's method, *H. pertussis* decloroizes readily,—more readily than *H. influenzae.* Microscopically, *H. pertussis* appears as a small, faintly stained coccoid bacillus, occurring singly, and scattered evenly throughout the film. Freshly isolated cultures practically never grow in threads. Frequently they show bipolar staining.

All suspicious cultures should be finally tested for agglutination with a monovalent positive rabbit serum produced by immunization with a freshly isolated culture; and also with a control normal rabbit serum. A portion of a colony is smeared on a clean slide into two small droplets of salt solution. To one is added a loopful of known positive *H. pertussis* serum 1-10 dilution. To the other is added an equal amount of normal rabbit serum. After thoroughly mixing, the smears are dried, fixed and stained in the usual way with gram stain. If the isolated culture is *H. pertussis,* it will be observed in clumps with the positive serum; while with the normal serum the culture will remain evently scattered throughout the smear.

Usually a definite diagnosis can be made on the third day after taking the cough plate. Then the infectious child can be quarantined or isolated to prevent further exposure and spread.

PHASES OR TYPES OF H. PERTUSSIS

Leslie and Gardner,[6] in studying a number of strains, concluded that *H. pertussis* is a uniform species when first isolated from the human subject. However, after subculture on various laboratory culture media, it passes through a series of antigenically distinct phases which they have designated phases I, II, III, and IV. They believe that phases I and II correspond to the smooth type colony, and phases III and IV to the rough colony. This classification attracted considerable attention, and many workers have restudied both old and freshly isolated cultures of *H. pertissus* in order to determine the feasibility of this classification.

It is now practically agreed by most laboratory workers that *H. pertussis* does undergo a gradual change in colony formation, when carried on ordinary culture media, from a small smooth transparent type to a larger rough sticky colony, unless the media contains a high percentage of fresh blood. The morphology of the organism also changes from a small ovoid organism which grows singly, to one larger and longer, which may grow in long threads. As the organism changes in morphology, it apparently loses in virulence, and antigenicity. While no one seems to have been able to distinguish between all the four phases of Leslie and Gardner, practically all observers are agreed that there are at least two distinct phases of *H. pertussis*. Toomey [9] studied the phases of *H. pertussis* by cross agglutination, and concluded that the cultures pass through various phases of antigenic activity before they reach a resting state. He was unable to reveal any distinction between phases III and IV. Toomey concludes that if Bordet's classification of state I should be interpreted as meaning the virulent or disease producing phase, and state II the resting or avirulent state, this would be a subdivision broad enough to include all types and phases of this organism.

IMMUNIZATION

Whooping cough vaccine has been used for many years by certain physicians for the prevention and treatment of whooping cough. The great irregularities which were encountered by the earlier users of whooping cough vaccines can now be understood in the light of our present knowledge. Much of the vaccine formerly used has been prepared from a non-virulent culture which had been carried in the laboratory, and the dosage in most cases was inadequate.

Madsen [10] was the pioneer who placed pertussis vaccination on a scientific basis. It was from his laboratory that the cough plate method of diagnosis was developed. This method for early diagnosis not only enabled a better control of the contagion, but it also furnished an ample supply of freshly isolated virulent cultures for the preparation of a potent vaccine.

Madsen showed that whooping cough could be largely controlled in a community by the use of a potent vaccine, as demonstrated by him in the Faroe Islands in 1923 and in 1929. A summary of the results of vaccination in these two epidemics showed that the mortality in the vaccinated group was one-sixteenth of that in the non-vaccinated group; and also that the disease in the vaccinated group had a much milder course and shorter duration. Madsen states that the explanation of the favorable results of vaccination in the Faroe Islands probably rests on three factors, namely, the vaccine was made from freshly isolated strains, large doses were used, and vaccination was completed before the onset of the epidemic.

Sauer [11] has contributed a number of articles, and much important information on the diagnosis and prevention of whooping cough. He has confirmed the results of Chievitz and Meyer and others, that the cough plate method is a practical and reliable method for the early diagnosis; and he has demonstrated that a properly prepared whooping cough vaccine, given in adequate dosage, will protect against whooping cough. He has also shown that young children tolerate the large doses of vaccine, and that probably the best time for immunization is the second half year of life. His carefully controlled demonstrations have given physicians and health officers assurance that whooping cough may be prevented and eventually controlled.

Kendrick and Eldering,[8] of the Michigan

Department of Health, report studies in pertussis immunization which have been in progress since 1932. They have conducted carefully controlled experiments in immunization with whooping cough vaccine, and their results would indicate that whooping cough may be prevented by the use of a vaccine.

Doull, Shibley, and McClelland [13] report the use of whooping cough vaccine in 483 Cleveland children, with 496 selected from the same neighborhoods as controls. They report sixty-one attacks of whooping cough among the vaccinated and seventy-one among the controls. They state that it was the opinion of physicians who saw both groups that the attacks in the vaccinated group were milder. This study is being continued and a final report will be made later.

PREPARATION OF VACCINE

From five to seven recently isolated strains of *H. pertussis* are used in the preparation of the improved whooping cough vaccine. These strains are selected from widely separated sections of the country, and not from one locality. Although colony formation, hemolysis, morphology of the organism, and ability to be agglutinated with monovalent pertussis antiserum produced in rabbits, is sufficient for the diagnosis of whooping cough, the selection of cultures for vaccine preparation is in addition based upon virulence for mice, ability to produce skin lesions in rabbits, and power to produce agglutinating serum in rabbits, the titer of which compares favorably with a designated standard of monovalent rabbit serum. Therefore, only highly potent strains are selected for use in the vaccine.

The selected cultures are grown for forty-eight hours at 37° C., on regular Bordet-Gengou media to which 15 per cent fresh calf or sheep blood has been added; after which the organisms are suspended in physiological salt solution. The vaccine is then adjusted so that each cubic centimeter contains 10,000 million bacteria, and the organisms are killed with Merthiolate 1:10,000, or phenol 0.5 per cent, being allowed to act in a refrigerator for a week or more. This is essentially the method of preparation as described by Kendrick and Eldering.[8]

In addition to tests for sterility and nonviability, each batch of vaccine is tested for its agglutinin ability with serum prepared against freshly isolated, virulent strains of *H. pertussis.*

DOSAGE AND ADMINISTRATION

The optimum dosage and method of administration of whooping cough vaccine has not yet been definitely determined. It is generally agreed that the original doses were too small, and that it probably requires from 5 to 10 cc. of a 10,000 million vaccine to adequately immunize a child against whooping cough. Many physicians follow the recommendation of Sauer and give one cc. in each arm followed by 1.5 cc. and 1.5 cc. in each arm at weekly intervals, making a total of 8 cc.

The Michigan Department of Health recommends four doses of one cc., 1.5 cc., 1.5 cc., and 3.0 cc., at weekly intervals, the last dose being given half in each arm, making a total of 7 cc.

Paterson, Bailey and Waller [12] recommend six doses of 1.0, 1.5, 1.5, 1.5, 1.5, and 1.5 cc. given at three- to four-day intervals, making a total of 8.5 cc.

The most satisfactory method is apparently the one that allows an adequate amount of a potent vaccine to be given without causing too much reaction. Therefore, the exact dosage and time interval may be adjusted by the physician.

The optimum time for children to be immunized against whooping cough is about the sixth month, though it may be started as early as the fourth month. Usually there is less reaction in infants than in older children.

WHOOPING COUGH CONTROL

The groundwork has been laid for the control of whooping cough. The cough plate method of diagnosis has proved so successful for making a diagnosis in the early catarrhal stage that plates should be made easily available for all practicing physicians and health officers. Physicians should be encouraged to

take cough plate cultures of all suspicious cases. Diagnosis can thus be made and the case quarantined or isolated before others are exposed. Early diagnosis by the physician in coöperation with the hospital or health department laboratory should tend to reduce the incidence of whooping cough. Parents should be encouraged to coöperate with their physicians regarding the immunization of their children against whooping cough.

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INFERTILITY IN WOMEN

MATERNAL WELFARE ARTICLE NUMBER SEVENTEEN

By ALFRED MEURLIN, B.S., M.D., East Orange, N. J.

Presented at the Staff Meeting of the Homeopathic Hospital of Essex County, East Orange, N. J.

Infertility may be defined as a lowered ability to bear offspring; in a narrower sense, the failure to become pregnant.

Cary, in reviewing the statistics from twenty-nine reporters covering 2150 sterile unions, shows a male responsibility in 33 per cent of the cases. Macomber recently has stated that more critical examination of the semen indicated male deficiency in 45 per cent of his cases.

Moench, in a recent article on sterility, has again stressed the frequency of male responsibility based on abnormal sperm morphology, and the importance of painstaking semen examinations. He has also emphasized the occurrence of germ plasm defects of which we have little knowledge at present except through spermatic morphology.

Bland has called attention to the large percentage of sterile marriages resulting from gonorrhea (30 to 50 per cent), especially of male origin.

Examination of the male should include a competent physical and genito-urinary examination as a preliminary to further study of the woman. A thorough history and physical examination of the female should then be made.

It is admitted that certain conditions must be met for a woman to become fertilized. It is usually necessary that a motile sperm with normal plasma penetrate a normal ovum somewhere along the channel of the Fallopian tube. The migration of the spermatozoa may be mechanically interfered with at certain points along the genital canal. The most frequent points at which such obstruction may occur are at the introitus (occasionally due to failure of normal coitus), the cervical canal, and in the Fallopian tubes. The impediments may be broadly classified as congenital, inflammatory, physio-chemical, and endocrine.

ENDOCRINE DYSTROPHIES

These form a small but definite class of patients with a lowered fertility.

1. A deficiency of the *anterior pituitary gland*, which when excessive gives the clinical picture of Frohlich's Syndrome and in its milder manifestations presents patients who are short, stout with masculin escutcheon and the characteristic mammary mons girdle obesity.

2. *Hypoövarianism*, or primary ovarian

failure, on the other hand, presents the excessively feminine type of individual, who may menstruate infrequently, irregularly and in scanty amounts. Hormone studies reveal a low estrogen level in the blood premenstrually. Endometrial curettings taken in the premenstrual phase are of value as indicating a failure of ovulation and deficient corpus luteum formation. We have found Novak's suction curette of great value in obtaining these specimens with the minimum of discomfort to the patient.

3. At times *hypo-thyroidism* may be a cause of lowered fertility. The clinical picture is familiar to all. Basal metabolic readings should be made routinely.

VAGINAL STRICTURES

Atresias and strictures of the vagina may be congenital or acquired. The usual congenital lesions are imperforated hymen with or without other malformations such as double uterus. In the acquired form, gonorrheal vulvo-vaginitis in infants and young girls has been ascribed as a frequent form. Burns and cicatrical scars and atresias following the use of poorly prepared iodoform packs have occurred. Also acute vulvitis, complicating diphtheria, scarletina or measles have been reported as causative of atresias.

Later in life, trauma and scarring resulting from brutal intercourse, child bearing or injuries, may rarely be a factor in stenosis. Operative procedures, as the removal of tumors, may set up partial or total obstructions.

Deep lacerations of the perineum may prevent the retention of semen and possibly reduce fertility.

SPASMODIC CONTRACTURES

Reflex spasmodic contractions of the levator ani muscle or vaginismus may prevent entrance of the male organ. This may be incited by a vaginitis, fissure or rectal condition, but it can occur without any local pathology being present. In the latter case there is usually an associated psychoneurosis. Some of these individuals do become pregnant, but the majority do not conceive. For them a great deal can be accomplished if they are willing and anxious to coöperate.

Case 1.—Mrs. S., twenty-seven years old, white, married four years, C. C. Sterility. Had suffered from dyspareunia and nervousness for past four years. P. H.: Measles, scarlet fever and T and A, when a child. Had an episiotomy two years previously without relief from present complaint. Menses 13 x 28 x 4 regular, moderately profuse and not painful. F. H. irrelevant. Urine and blood count negative. Blood Wassermann negative. Pelvic examination revealed a spasmotic contraction of the sphincter vaginae at the least touch of the examining finger. There was a scar in the fourchette from the previous operation. As far as it was possible to determine, the uterus was normal in size and position. The adnexa were negative.

Treatment consisted of the insertion of a small Graves bivalve speculum, which was gradually opened further at each visit and left in the dilated position for ten minutes. She was given a five per cent cocaine ointment, and instructed to use it before having intercourse. She became pregnant within two months.

It may be necessary in certain cases to do an episiotomy, bringing the cut edges together from above downward instead of from side to side to widen the introitus.

Rarely do changes in the pH of the vaginal secretions cause an unfavorable media for the spermatazoa. Septa, spurs, and constrictions from scars may interfere with the formation of a seminal pool in which the cervix normally dips.

STATE OF THE CERVIX

In considering pathological states of the cervix, the one most frequently seen is an endocervicitis with the formation of a heavy plug of mucus filling all or part of the cervical canal. This may occur *without* erosion. The sperm cell enters into this sticky mass, becomes entangled in the heavy mucus and is unable to proceed further. The cervix is rarely involved alone in congenital hypo-plasia. A stenosis of the canal at either the external or internal os is frequently combined with various degrees of maldevelopment of the uterus.

The pin-point os is often spoken of as a cause of sterility. Such well-known gynecologists as Hirsch, Posner and Childs contend that any opening large enough to allow the passage of menstrual blood could not be small

enough to keep out spermatazoa. Many students of sterility, however, maintain that stenosis of the cervix is a frequent cause of sterility and base their claims upon the clinical facts. They do not believe that the mechanical narrowing of the canal of itself prevents the passage of the sperm; but that there is a physiochemical change in the secretion of the cervix resulting from improper drainage. This is further borne out by insemination tests, according to the method described by Hühner, whereby the male element is found to be slowed in its flagellate movements at the level of the stricture. Also by the therapeutic test that dilatation alone frequently cures the sterility.

FALLOPIAN TUBES

The examination of the Fallopian tubes as an etiological factor in sterility has been put on a very accurate and scientific basis by the work of Rubin, Peterson, Jarcho, Cary and others both here and abroad. We frequently find a complete or partial occlusion, due to a chronic and quiescent salpingitis, the presence of kinks and adhesions, tuberculosis, and tumors.

The two chief methods of investigating the patency of the tubes, aside from the usual bimanual examination, have been the insufflation of certain gases such as oxygen, carbon dioxide, and air; and the instillation of contrast media such as sodium iodide, sodium bromide, iodipin, neoskiodan, and lipiodol. Such examination should not be made until two years after any local inflammatory condition has subsided. Our own experience has been limited to air, carbon dioxide, and lipiodol. Lately, in spite of some adverse reports in the literature, we have come to place the greatest reliance upon lipiodol for several reasons. It has never in our hands caused any peritoneal irritation, as evidenced by subjective symptoms or physical signs. It is easier to handle than the gases in the various apparatus evolved for injecting them. It is an excellent contrast media for the x-ray. A gentle hydrostatic pressure is required to force the oil through the tubes, thus avoiding a spasm of the tubal sphincter as described by Arnstam and Reinberg. It has a marked therapeutic effect in opening up occluded tubes.

As illustrative of this action, the following case, which is now under treatment, will serve to bring this out:

Case 2.—Mrs. R. M., aged thirty-four; married seven years. The work-up on herself and husband showed no abnormalities with the exception of an obstruction to the passage of air in the Fallopian tubes. A patency could be obtained at 200 mm. of Hg. pressure. Insufflation repeated seven times at this level failed to increase the patency by opening up the tubes.

Subsequently a lipiodol injection was done. None of the oil passed through again until a level of 200 mm. of Hg. was reached. The x-rays showed in the first examination the left tube to be irregularly outlined. In the second roentgenogram, the left tube is well outlined, and the right is outlined indistinctly, the lipiodol is collected in small globules, apparently in the peritoneal cavity.

Several injections of air made since the oil injection passed at 80 mm. of Hg. pressure.

SUMMARY

1. We have attempted to show the necessity of accurate and complete determination of the one of several factors reducing fertility in both sexes before instituting treatment.

2. We have attempted to again emphasize that sterility is a problem of the couple.

3. In cases where the female is responsible, we have described some of the more common causes.

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Macomber: The Encyclopedia of Med.

STATE SOCIETY ACTIVITIES

ADDRESS OF WELCOME

BY WILLIAM G. HERRMAN, M.D., PRESIDENT OF THE MEDICAL SOCIETY OF NEW JERSEY, TO THE AMERICAN MEDICAL ASSOCIATION AT THE OPENING OF ITS 88TH ANNUAL CONVENTION, ON JUNE 8, 1937, IN ATLANTIC CITY

President Heyd, Distinguished Guests, Ladies and Gentlemen, Fellow Members of the American Medical Association:

The oldest society of organized medicine in the United States welcomes the largest and most potent medical organization in the world again to the premier convention city of America.

The Medical Society of New Jersey was founded in 1766. The American Medical Association evolved out of several inter-state meetings in 1847. New York State played the premier part, but it had assistance from Connecticut, Pennsylvania, New Jersey, and Georgia. Our State Society cannot therefore be called an offspring of the A. M. A., but rather a progenitor, although it is *now* one of her children. Like an older child, it sometimes professes to know more than the parent. Sometimes it does, but sometimes it has to be put in its place.

While, as a Society, we may be hoary with age, the present membership is full of vim and vigor. If, perchance, we try to go ahead too rapidly in finding solutions for the problems that face all of us, it is with the best intent in the world,—our heart is in the right place. We are loyal to you in principle; we admire you, although we sometimes differ with you as to the means to an end. We hope you will make use of us; and we hope that in the future you will make more use of us as a Society and individually, as well as of our State and this fair city.

We know that your scientific sessions and exhibits during this week will be of great value to the welfare of all our people. We trust that your business and economic deliberations will help solve some of the problems facing the profession; will help to point the way toward better economic stability of the profession, so that it may give greater service to the public.

We hope that you will all have a good time.

FEDERALIZED MEDICINE

A COMMUNICATION FROM PRESIDENT W. G. HERRMAN

The psychologist Jung, of Switzerland, states that human government goes through three phases: Democracy, dictatorship, aristocracy,—and then a return to democracy. These phases may not necessarily be of equal duration, but they follow one another in the above order. When political and economic conditions are such that the bulk of the people want only as much government as is necessary to control their mutual relations, democracy prevails. During such times there is prosperity and opportunity, and the average citizen is interested in how far ahead he can go, and so he wants as little interference with his daily life as possible.

When political, economic, or social depression comes on, as the result of war or other upheaval, then the average citizen is not so much interested in how far forward he can go, as he is concerned as to how far backward he may fall. He then calls for help, and this is the stimulus which produces strong centralized governments and dictators. The people in return for bread, butter, and clothing, are then willing to give up national liberty for personal protection. When the strong centralized government is once enthroned, it changes only with returning prosperity and peace, to a monarchial type of government, and this era lasts until such time that the great bulk of citizens become dissatisfied with supporting their former protectors.

In many parts of the world today, we see either a fully developed centralized government under a dictator, or a strong tendency toward the development of one. Whether or not such

a government develops in this country will depend entirely upon what the great middle class of citizens, generally inarticulate, allow others to bring upon them. They have the decision entirely within their own hands. The future will not be decided by the indigent, nor by those who are financially strong. This middle class element, composed of the small merchants, the farmers, the skilled artisans, the professional men, and the so-called white-collar class, can have any form of government which they demand, but if they remain quiet while changes develop, they cannot blame anyone for considering their silence as acquiescence. If, on the other hand, they are not willing to surrender liberty for immediate necessities, they should promptly state this. The various groups that go to make this large body of citizenship must know that the interests of one are the interests of all.

Federalized medicine, if it comes, would be only a part of federalization of all our economic and social life. It may be the forerunner, but it is not the whole story. Federalization of medicine or other phases of our social life would need a vast increase in government revenue, and hence increased taxation. The power to tax is the power to destroy, when it is carried to excess. It may result in the confiscation of property, or the restriction of personal liberty. When government interest in the individual's income becomes sufficiently large, then the government becomes intimately interested in the individual life of every citizen. That point is being rapidly reached in this country. It has been estimated that forty-eight cents out of each dollar of income goes into taxation, either direct or indirect. If this be true, then government has nearly a fifty per cent interest in the productive power of every citizen. I quote from the Washington "Merry-Go-Round":

"There was considerable excitement when Senator Jim 'Ham' Lewis proposed a plan for federalized medicine to the American Medical Association. There would have been much less if it had been realized that Uncle Sam, with his doctor's bag in his hand, already has a thriving practice. * * * The Resettlement Administration has made thousands of loans to farmers. A sick farmer cannot raise a crop to pay back a loan, so R. A. considered it good business to keep the farmers well. Two different plans have been tried. Under one of them, money was loaned to farmers to pay doctors' bills, and a corporation was created that entered into an arrangement with doctors whereby they cut their fees one-third. This has been widely done in North Dakota. The other is socialized medicine, pure and simple. Resettlement sets up medical coöperatives, each member paying a certain sum and the doctor receiving a fixed income."

Our Senators and Representatives in Washington want to represent their citizens. If they hear only from a certain class who are noisy and demanding, and all others remain silent, our Representatives can hardly be blamed if at times they misinterpret the wishes of their constituents. The relation of the American Medical Association to us as physicians is similar to that of the government at Washington to the people in general. At its recent convention at Atlantic City, the American Medical Association went on record officially as follows:

> "The American Medical Association reaffirms its willingness on receipt of direct request to coöperate with any governmental or other qualified agency and to make available the information, observations and results of investigation together with any facilities of the Association, which may be necessary for reaching a decision and forming plans."

If the American Medical Association does not hear from the "folks back home", its leaders can hardly be blamed for taking it for granted that the action at Atlantic City meets with hearty approval; and, furthermore, cannot be blamed if they proceed from the general to the specific as their judgment may direct, unless they hear definitely from those most interested.

Your President feels that, whether the possibility of completely federalized medicine is a near or is a remote possibility, the time to make our wishes known and the time to take our stand as a component society is now, not *after* the event has occurred. He feels that the Society should place itself on record as to how far it wishes to see this trend proceed, and that it should respectfully submit its point of view to the national organization.

Your Welfare Committee met on Sunday, June 27th, and devoted two hours to a general discussion of the subject. The members voted that the President's Cabinet, with additional members selected by the President, should meet and draw up resolutions which they feel would represent the wishes of the Society at large. These resolutions will then be submitted to the Welfare Committee at a meeting to be called in the near future; and if approved by it, they will then be submitted to the Board of Trustees.

CONTACTS WITH LAY HEALTH ORGANIZATIONS

Too long the physicians of New Jersey—and of all the other States—have held themselves aloof from intimate contacts with other groups which are promoting the services of health. During the past three years it has been the policy of The Medical Society of New Jersey to establish friendly contacts with all these groups. Physicians clearly recognize their prerogative to *produce* medical services; but misunderstandings arise regarding the *distribution* of those services.

There has been a disposition on the part of welfare groups to assume a dominating part in determining the methods by which physicians shall render their services to large groups of people who either cannot, or will not, seek the services of their family doctors along lines which have hitherto been overlooked,—the treatment of syphilis for example. Large groups of welfare workers are planning methods by which all cases of syphilis shall be given the benefits of medical treatments which physicians alone can give. The welfare workers adopt modern methods of publicity and high pressure salesmanship which physicians instinctively avoid. But within the last two or three years the Medical Society has gradually developed methods of popular publicity, and its representatives are now ready to sit down with those of welfare organizations and define the part which each shall assume in the great work of a more equitable distribution of medical services.

The newspapers and the radio are giving wide publicity to measures for the treatment of syphilis; and an impartial review of the proceedings of conferences like that on the control of syphilis reveals a sincere desire on the part of both physicians and welfare workers to reach agreements which shall be satisfactory to both groups. Each group needs the assistance of the other, and there is a definite field of service for each.

The Handbook of Preventive Procedures of Family Doctors is sufficient evidence that practicing physicians are sincerely preparing themselves for the delivery of those services which they can give spontaneously and gladly, provided mutual agreements are reached.

The policy of The Medical Society of New Jersey that its representatives shall make intimate contacts with welfare groups is bearing abundant fruit which has become increasingly evident during the past few months.

A NATIONAL HEALTH POLICY

The following resolution on "The Development of a National Health Program" was adopted by the House of Delegates of the Medical Society of the State of New York on May 24-27, 1937, and was submitted to the House of Delegates of the American Medical Association on June 7, 1937 (Journal of the A. M. A., June 19, 1937, page 2142). This resolution was the basis of an extensive discussion in an executive session of the A. M. A. House of Delegates, and also in the meeting of the Welfare Committee of The Medical Society of New Jersey on June 27, 1937 (page 462).

PRINCIPLES

1. That the health of the people is a direct concern of government; and a national public health policy directed toward all groups of the population should be formulated.

a. In the formulation of such policy the opinions and suggestions of organized medicine should be given preference.

b. That the House of Delegates of the A. M. A. create a group which shall formulate the principles and proposals of a national health policy to be submitted to the government.

2. That adequate medical care is an essential element of public health; and local, State and Federal Governments need to supplement present efforts of the medical profession to provide it.

a. That the House of Delegates of the A. M. A. establish a working definition of the term "adequate medical care" suitable for the purpose of discussing national legislation and social legislation.

3. That the problem of economic need, and the problem of providing adequate medical care, are not identical and may require different approaches for their solution.

a. Principle three implies that the problem of providing the individual with the means of securing medical care—that is, the economic needs—and the problem of distributing medical services are not

identical; that these problems of economic needs should be approached separately from those of distributing medical services to the people.

PROPOSALS

1. That the first necessary step toward the realization of the above principles is to minimize the risk of illness by increasing preventive efforts through extension of public health services,—Federal, State and local.

a. That the extension of Federal, State and local preventive health measures is approved, provided it meets the needs of a given situation in the opinion of the medical profession in the locality affected; and provided it integrates to the greatest possible extent the private practitioner of medicine in the development of preventive health services.

2. That the immediate problem is provision of adequate medical care for the medical indigent, the costs to be met from public funds.

3. That public funds should be made available for the support of medical education, and for studies, investigations and procedures for maintaining the present high standards of medical practice. This support shall have the majority opinion of organized medicine to recommend it. If this is not provided for, the provision of adequate medical care may prove impossible.

4. That public funds should be available for medical research as essential for high standards of practice in both preventive and curative medicine.

5. That public funds should be made available to hospitals that render service to the medically indigent, and for laboratory diagnostic and cosultative services.

a. That the provision that these consultative and laboratory diagnostic services shall be established only in regions where the medical profession approves the need for same, and after consultation with the local medical profession in the area affected.

6. That in the allocation of public funds, existing private institutions should be utilized to the largest possible extent; and receive support as long as their service is in accord with the above proposals.

a. That in so far as the allocation of funds is concerned for these institutions, they should not be made on a pro rata population basis, but should be limited strictly by the needs of given institutions in specified localities; and the allocation should have the approval of the medical profession in the locality in which the institutions are located.

b. That in the selection of existing institutions to which public funds may be allocated, their rating and their needs shall be measured by the standards of the Council on Medical Education and Hospitals of the A. M. A.; and that no public funds should be made available to existing institutions against and contrary to the majority opinion of the medical profession in the locality in which they exist.

7. That the investigation and planning of the measures proposed, and their ultimate direction, should be assigned to experts.

a. It being recommended that the various subdivisions of the A. M. A., namely, its national, State and county components, furnish to the government on request, lists of experts in their communities to carry out these principles and proposals.

b. That the word "expert" is taken to mean a man especially qualified by experience in his specific field. Nominations of these "experts" should be by units of organized medicine. The nominations and recommendations by organized medicine should be given preferential consideration by government in making its selection.

8. That the adequate administration and supervision of the health functions of the government, as implied in the above proposals, necessitates, in our opinion, a functional consolidation of all Federal health and medical activities under a separate department.

9. That we who subscribe to the above principles, proposals, and recommendations hold the view that compulsory health insurance does not offer a satisfactory solution on the basis of these principles and proposals, and repeat our objections to its enactment in this country.

Therefore, Be It Resolved, That the House of Delegates of the A. M. A. endorse the principles, proposals and recommendations just cited; and

Be It Further Resolved, That the House of Delegates authorize the formation of a committee which shall, in conformity to the above, formulate a national health policy for submission to the government; and further be empowered to confer with government agencies and also with any other medical groups so that differences in conception, definition of terms, and applicability of principles and procedure may be ironed out in conference regarding those matters in the above principles and proposals which are of national scope and to the end that they may be enacted.

WELFARE COMMITTEE

The first meeting of the newly appointed Welfare Committee of The Medical Society of New Jersey was held in the Berkeley-Carteret Hotel, Asbury Park, N. J., on the afternoon of Sunday, June 27, 1937, the Chairman, Dr. Hilton S. Read, Atlantic City, presiding, and the following members present:

EX-OFFICIO

William G. Herrman, President
Alfred Stahl, Secretary
LeRoy A. Wilkes, Executive Officer, and Secretary of the committee

COUNTY SOCIETY REPRESENTATIVES

Atlantic—
Hilton S. Read, Chairman
Myrtile Frank — Anthony G. Merendino

Bergen—
Samuel Alexander — Charles Littwin

Camden—
Ernest G. Hummel — R. L. Sharp
Thomas K. Lewis

Cumberland—
Leslie E. Myatt

Essex—
Arthur W. Bingham — Henry B. Orton
E. P. Cardwell — Theodor Teimer
J. Irving Fort — E. LeRoy Wood
John W. Gray — A. Charles Zehnder
Raymond J. Mullin

Gloucester—
Chester I. Ulmer

Hudson—
A. E. Jaffin — James F. Norton
Charles B. Kelley — T. J. Schuck

Mercer—
D. Leo Haggerty

Middlesex—
Henry Haywood — Jacob J. Mann
Edward F. Klein — Joseph H. Kler

Monmouth—
C. Byron Blaisdell — Barclay W. Moffat
John C. Clayton — Stanley Nichols
J. Berkeley Gordon — Edwin G. Dewis

Morris—
George J. Young — Byron G. Sherman

Ocean—
Eugene G. Herbener

Passaic—
Sigurd W. Johnsen

Salem—
David W. Green

Somerset—
Frank L. Field

Union—
Frederic W. Lathrop — Herschel S. Murphy

Warren—
W. H. Varney

The following members had sent their regrets and were excused from attending the meeting:

Millard F. Sewall, Cumberland
Julius Levy, Essex
B. S. Pollak, Hudson
Allen G. Ireland, Mercer
Wright MacMillan, Passaic
Charles H. Schlichter, Union

The roster of the Welfare Committee showed that eighty-two per cent of its members were present or accounted for. In addition there were present Dr. W. J. Carrington, President-Elect; Dr. W. B. Morris, Second Vice-President; Dr. F. J. Quigley, Past President; Dr. Frank Overton, Editor of The Journal; and a number of members of Advisory Committees which were holding their meetings for organization.

The minutes of the last meeting of the Welfare Committee, held on April 4th, 1937, were approved in the form in which they were published in the April Journal, page 284.

THE ADMINISTATIVE YEAR

It was announced that the policies of the newly elected and appointed officers and committees would be published in the near future; and that the Welfare Committee and several of its advisory committees were meeting today for the purpose of adopting definite projects, and of developing methods for carrying them on during the administrative year. The official committees of The Medical Society of New Jersey are composed of about 200 members, each of whom has a knowledge of things done in the past year and opinions of what should be done this year. Express your judgment and your plans to your chairmen and to the President; and they will assemble your views into a harmonious plan to which each has made a personal contribution.

FIELD PHYSICIANS

Dr. William J. Carrington, President-Elect, spoke of the responsibilities and opportunities of The Medical Society in the relation of the Medical Profession to the Federal Government in the application of the Social Security Law in New Jersey. The government has accepted the challenge of the physicians of New Jersey that they can and will institute a practical system of medical care for those who are not now receiving it, or are unable to apply for it because of financial, social, or other non-medical conditions which are beyond the control of the patients. Field Physicians would be nominated by the Welfare Committee of The Medical Society of New Jersey, and would be

paid by the Federal Government. If the Field Physicians should prove inexperienced or incompetent, the Federal Government would assume control of their appointment, and the Medical Profession would lose its opportunity to demonstrate its willingness and ability to direct the service.

Dr. Carrington called upon the representatives of each county to give careful consideration to the nomination of its Field Physician. The representatives of several counties replied that their counties are already considering the qualifications of their appointees, and would make their nominations in the near future.

TRAINING PHYSICIANS IN PRACTICAL MEASURES OF PUBLIC HEALTH

Dr. Stanley Nichols, Chairman of the Sub-Committee on Public Health, discussed the measures on which it is necessary to instruct some of the practicing physicians, especially family doctors, in the methods of diagnosing and treating the conditions in which the Federal government is especially interested. The particular point which he emphasized was that while specialists could give efficient service in those lines, the family doctors should be given the opportunity to learn the essentials of those subjects, such as venereal disease practice, in which they have hitherto not taken an active part. Dr. Nichols described three measures which the Welfare Committee should undertake:

1. The preparation of brief articles and pamphlets to be published in The Journal and reprinted for distribution to the family doctors.

2. The adoption of short courses of lectures on the subjects, to be given at centers which will be readily accessible to family doctors, especially those living in sections where the facilities are not now available.

3. List existing places, or establish new centers, in which family doctors may receive practical instruction in such subjects as Mantoux testing for tuberculosis, and the administration of arsenicals for syphilis. By this means the committee may assist the family doctor in entering upon lines of practice in which he is not now engaged; and may also lead and inspire him to enter upon the practice of preventive medicine and public health on a more extensive scale than ever before.

Dr. Nichols also emphasized two points in which the Welfare Committee should assume the leadership:

1. To establish scientific standards for centers of treatment, including their physical equipment, and the choice of qualified directors of the services.

2. To define the conditions under which the centers shall give free treatments to patients; and to give the attending physicians authority to judge each patient as to his condition—economic as well as physical.

PUBLIC RELATIONS

Dr. J. H. Kler, Chairman of the Sub-Committee on Public Relations, briefly outlined the scope of his committee in giving information to the people. The committee has developed an extensive amount of experience during its one year of intensive activity; and now it invites the opinions of practicing physicians regarding the particular lines of activity which will secure the response of the people.

Dr. Kler stated that the Sub-Committee had held a preliminary meeting at which it had made a tentative analysis of its field of work, and of the methods which were open to it, especially newspaper publicity of local public health activities. He had been much encouraged by the cordial acceptance of articles by local editors. The attitude of the editors was entirely satisfactory. The responsibility for efficient utilization of the space freely offered by the newspapers was the responsibility of the Welfare Committee.

A NATIONAL POLICY IN PUBLIC HEALTH

Dr. William G. Herrman, President of The Medical Society of New Jersey, said that since the date of the last meeting of the Welfare Committee, which was held on April 4, 1937, an acute condition in the national health policy had arisen because of the formal presentation of "The Development of a National Health Policy" by the Medical Society of the State of New York to the annual meeting of the House of Delegates of the American Medical Association on June 7, 1937, as described in the A. M. A. Journal of June 19, page 2142. The New York report is re-printed on page 460 of this Journal.

This New York report was considered in an executive session of the A. M. A. House of Delegates, and an accurate report of the proceedings is not available. However, it was the occasion of the appearance of the Hon. J. Hamilton Lewis, United States Senator from Illinois, and a member of the Social Security Committee, before the House of Delegates on June 10, on the invitation of the House. Senator Lewis delivered an address which fills seven columns of the A. M. A. Journal of June 26, pages 2221-2224. Senator Lewis was considered to be the spokesman of the Federal Government in regard to its public health plans.

President Herrman read two brief statements which he had prepared on a national health policy; but before publishing them, he requested permission to submit them to a meeting of the President's Cabinet for consideration and approval of its members. One paper was on the philosophy of the present situation; and the second set forth a series of principles of the attitude which The Medical Society of New Jersey might adopt.

Dr. Herrman concluded with a plea to the members of The Medical Society of New Jersey to develop a plan of medical service to the people along the lines which the Society is already putting into operation, the essential point being to evolve a form of medical service which the people will accept, for "If the people do not support themselves, the government will not support them."

THE BACKGROUND OF THE NEW YORK PROPOSALS

Dr. Thomas K. Lewis, Chairman of the Board of Trustees, gave a well-considered address on the background of the National Health Movement as revealed by the address of Senator Lewis. He mentioned some of his own conclusions based on inquiries among the Congressmen from his section of the State. It was his opinion and advice that The Medical Society of New Jersey should continue to develop its own plan of action in which it had already made more progress than any other large group of practicing physicians. At the same time, the Welfare Committee should study all phases of the problem as they are stated by the national leaders both medical and political. He felt that the essential action of every physician of New Jersey was that he should apply the newer principles of practice to his own patients, in their own homes, rather than to send them to a hospital for his own convenience.

LEADERSHIP OF THE MEDICAL SOCIETY OF NEW JERSEY

Dr. Samuel Alexander, Chairman of the Committee on Constitution and By-Laws, gave a brief analysis of the present situation, beginning with a quotation from Carl Schurz:

"My country, right or wrong.
If right, keep her right.
If wrong, make her right."

Our greatest need is to demonstrate a definite standard of medical practice with special consideration of two groups:

1. The unemployed.
2. The unemployables.

Three groups are responsible for the development of an efficient medical service:

1. The practicing physicians.
2. The local governments—municipal, county, and State.
3. The Federal Government.

When New Jersey develops its full program along the lines already begun, that program will be a model for the nation.

FINAL ACTION

On motion of President Herrman, he was authorized to submit his papers to the President's Cabinet, which should develop a tentative plan of action and send it to each member of the Welfare Committee.

The meeting adjourned at 3:50 o'clock.

OPINION OF THE ADDRESS OF SENATOR LEWIS BEFORE THE A. M. A.

The following official letter dated June 28, 1937, was received by Dr. Alfred H. Stahl, Secretary of The Medical Society of New Jersey, from the official State Medical Society of Maryland in regard to the address of Senator Lewis before the House of Delegates of the American Medical Association on June 10 (see the Journal of the A. M. A., June 26, 1937, p. 2221):

"At a special meeting of the Council of the *Medical and Chirurgical Faculty of the State of Maryland,* held on June 17th, 1937, the attention of the Council was called to a speech made at the Atlantic City meeting of the American Medical Association by Senator J. Hamilton Lewis on June 10th, 1937.

"You, no doubt, saw newspaper accounts of this speech under date of June 11, 1937. There was also an account in the magazine 'Time', June 21, 1937, page 26, in which the subject was reviewed at some length.

"At the special meeting of the Council of the Medical and Chirurgical Faculty of the State of Maryland, above referred to, the following resolution was unanimously adopted:

"At the Atlantic City meeting of the American Medical Association June, 1937, Senator J. Hamilton Lewis of Illinois appeared and delivered an address concerning the future relations between the State, the physician and the patient. He stated that as Chairman of a Senate sub-committee he came to the American Medical Association for guidance and advice in certain aspects of his duties. At the conclusion of his talk, the House of Delegates referred the matter to the Board of Trustees for consideration and action.

"The Council of the Medical and Chirurgical Faculty of the State of Maryland, being informed of the nature of Senator Lewis's views and the course that he predicts the future of medicine will take, herewith expresses its complete antagonism to any such development. Specifically we repudiate the view that the State does, or in the United States of America has any right to, regard the individual as a mere instrument for the execution of its purposes, in peace or war, and to that end may enforce the services of the medical profession to maintain the health of the citizen, without respect to the desires of either patient or physician. Not only is this view of governmental relations and powers a grave threat to the freedom, the quality, and the scientific development of the medical profession; even more important is the fact that it completely subverts the traditional rights of American citizens and is a treasonable betrayal of principles of our democracy. We believe that the Government has no direct concern with the health of the individual. Under its police powers, which assure the individual protection from the acts of others, it is concerned to prevent the spread of contagion and to restrain industrial conditions that are a menace to health and safety. The individual otherwise is free to take such care of his own health as seems best to him. Also, in general, the relation between physician and patient is a personal one beyond the concern of the government. In our view, the State is the servant of the people, not its master.

"Holding these opinions, not merely as abstract theories but as a sacred inheritance from our fathers and a sacred trust to be passed on to our children, we respectfully request the Board of Trustees of the American Medical Association as follows:

"1. That they publicly and emphatically repudiate the relationship of the government to the physician and patient envisaged in Senator Lewis's address;

"2. That they publicly and emphatically call to the attention of the people of the United States the danger that threatens their freedom as citizens and individuals;

"3. That they refuse, in the name of organized medicine, to have any share or responsibility in the introduction of such a scheme, by giving advice, the suggestion of personnel, or even by tacit acquiescence;

"4. That, on the contrary, they enlist the active and vigorous opposition of the entire medical profession against the scheme, to the extent, if possible, of pledging them to refuse coöperation in any such plan that may be adopted.

"Respectfully submitted,

"WALTER D. WISE, M.D., *Secretary.*

"P. S.—I am sure the Council of the Medical and Chirurgical Faculty of the State of Maryland would appreciate an expression of the reaction of your Medical Society to this matter.—WALTER D. WISE."

TRUSTEES' MEETING

The organization meeting of the Board of Trustees of The Medical Society of New Jersey was held in Haddon Hall, Atlantic City, on Wednesday, June 19th, 1937, at 1:30 p. m.

Dr. Thomas K. Lewis, of Camden, was elected Chairman, and Dr. Herbert W. Nafey, of New Brunswick, was reëlected Secretary.

NEW ACCOUNTING SYSTEM

Dr. North reported that an accountant was engaged to install a new accounting system for the Executive and Editorial Offices, and that a monthly audit of the accounts was planned. The report was unanimously approved.

SCIENTIFIC EXHIBITS

Plans for conducting the Scientific Exhibits at the Annual Meeting were discussed. It was felt that there was an abundance of scientific material available in New Jersey; and the success of the recent exhibits justified the preparation of definite and specific recommendations to be drawn up as standards for exhibitors in the future. This subject will be considered in detail at the next meeting of the Trustees.

AUDITING COMMITTEE

The Chairman appointed the following Auditing Committee to act during the coming year:

Dr. Watson B. Morris, Springfield, Chairman
Dr. Ralph K. Hollinshed, Westville
Dr. E. Zeh Hawkes, Newark

NEW YORK STATE HEALTH POLICY

A discussion was held in reference to the resolution adopted at the Annual Meeting of The Medical Society of the State of New York, for the formation of a committee to formulate a national health policy for submission to the government. A motion was made, seconded and unanimously carried that the Board of Trustees of The Medical Society of New Jersey is opposed to the principles and proposals as stated in this resolution; and that it should be referred back to a Special Com-

mittee of the House of Delegates of the A. M. A. for further study (see p. 460).

DIRECTORY OF PHYSICIANS

It was voted to participate with the Medical Society of the State of New York in securing data for the 1938 Medical Directory of New York, New Jersey, and Connecticut. The cost to New Jersey will be about $300, and the value of last year's Directory justifies the expenditure, especially since the data should be secured by New Jersey in any event.

FINANCE AND BUDGET COMMITTEE

Members of the Finance and Budget Committee were elected as follows:

Dr. Edgar A. Ill, in the place of Dr. Alfred Stahl

Dr. William F. Costello, in the place of Dr. Watson B. Morris

Dr. David B. Allman, in the place of Dr. William J. Sweeney

Dr. Herrman stated that the New Jersey Hospital Service Plan has agreed to place a member of our State Society on its Board of Trustees. Dr. Edward J. Sprague, of Newark, was unanimously chosen.

Drs. Stahl and Wilkes were appointed a committee to devise a plan for publishing the annual Official List of members of the State Society for 1938.

REPRESENTATIVE TO DENTAL SOCIETY

As to the appointment of an official representative from our Society to the Convention of the Dental Society of New Jersey, a motion was made, seconded and unanimously carried that the President be empowered to designate official representatives to the State Dental Society.

NEW ADVISORY COMMITTEES

As to the appointment of Advisory Committees on Medical Auxiliary Services, Pneumonias and Adult Health, a motion was made, seconded and unanimously carried that an Advisory Committee on Medical Auxiliary Services to the Medical Practice Committee be appointed by the President.

A motion was made, seconded and unanimously carried that two additional advisory committees to the Public Health Committee be appointed:

1. Pneumonia;
2. Adult Health.

It was voted that the personnel of these committees be left with the President for appointment.

PUBLISHING THE TRANSACTIONS

The Publication Committee was unanimously directed to publish the Transactions of the Annual Meeting of The Medical Society of New Jersey held on April 27-29, 1937.

Herbert W. Nafey, *Secretary*.

NEW JERSEY HOSPITAL ASSOCIATION

The winter conference of the New Jersey Hospital Association was held on January 27th, 1937, in the Academy of Medicine, Newark. The presiding officer was Mr. Edgar C. Hayhow, Superintendent of the Paterson General Hospital. About 200 representatives of the physicians, the hospital administrators, and the nurses were present.

Mr. Fred W. Heffinger, Executive Secretary of the Association and Superintendent of the Mercer Hospital, Trenton, read a resolution in memory of Miss Jessie N. M. Herrood, who was Superintendent of the Community Memorial Hospital of Montclair.

President Hayhow, in his address of welcome, expressed his deep satisfaction that the two great groups concerned with hospital service—the doctors and the administrative personnel—were meeting together for the first time for the express purpose of each learning the viewpoint of the other. The meeting is the result of a tentative meeting of the two groups in Bergen County about the middle of November, when the decision was made that at the next meeting the doctors should express their opinions of hospital administration; and at the following meeting, the administrators should advise the doctors.

ADDRESS OF DR. S. T. SNEDECOR

Dr. S. T. Snedecor, Hackensack, President of The Medical Society of New Jersey, presided during the scientific part of the program, and referred to the growing approach of the two groups of those who carry on the work of the hospital. A few years ago the physician was interested in hospitals principally because they afforded him the opportunity to practice medicine and surgery with ease and precision. But allied agencies have sprung up and proved themselves necessary,—public health departments, lay agencies, welfare service, and popu-

lar education; and now we physicians are giving serious thought to these programs, and to their integration into a unified service. A few years ago it seemed that all forms of medical service should be grouped around community health; but the hospitals are not prepared for that advanced step. For example, the American College of Surgeons felt that hospitals should have some kind of preventorium where doctors would bring their patients for health examinations; but the hospitals have no place or means for making the examinations. To complete an examination as the doctor does in his office, cannot be done in the hospital, unless extensive facilities are provided and methods developed,—and the question arises as to the advisability of the hospital entering that field at all.

Another problem is that of *insurance of hospital care*. This was started without the advice of the doctors; but in Essex County the doctors are actively engaged in developing plans in which each group will do its part to the satisfaction of the other groups.

Dr. Snedecor then introduced Dr. Edgar A. Ill, President of the Essex County Medical Society, who gave an address, which is printed on page 435 of this Journal.

The paper of Dr. Ill was then discussed by Mr. J. Douglas Colman, Executive Secretary of the Hospital Council of Essex County. This discussion is printed on page 438 of this Journal.

The next speaker was Dr. Harry H. Satchwell, Vice-President of the Essex County Medical Society and the leading organizer of the Medical-Dental Service Bureau of Essex County, whose paper is printed on page 440 of this Journal.

Dr. A. Charles Zehnder, Chairman, Committee on Nursing, The Medical Society of New Jersey, then outlined a system of training of nurses to serve in the *homes* of the sick. This paper is printed on page 443 of this Journal.

The next speaker was Margaret Ashmun, R.N., Director of Nursing, Orange Memorial Hospital, and President, New Jersey State Nurses' Association. This paper is printed in abstract on page 444 of this Journal.

Dr. Zehnder's paper was also discussed by Mr. Edgar A. Hayhow, President, New Jersey Hospital Association, whose paper is printed in abstract on page 446 of this Journal.

Dr. Thomas K. Lewis, Camden, Chairman, Medical Practice Committee of The Medical Society of New Jersey, gave a paper on Social Security and Hospitalization, which is printed in full on page 447 of this Journal.

The program closed with a discussion of Social Security and Hospital Relationships by F. S. Howe, Director, Orange Memorial Hospital, which is printed on page 449 of this Journal.

The eight papers which were presented were eminently practical, and covered the subject of hospital relations and implications clearly and broadly.

NEW JERSEY IN THE AMERICAN MEDICAL ASSOCIATION

The 88th annual meeting of the American Medical Association was held in Atlantic City, June 7-10, 1937. The year 1850 is credited with being that of the first formal meeting of the completed organization of the A. M. A., but the first assemblage of delegates from the several States was held in New York City, on May 5, 1846, on the invitation of the Medical Society of the State of New York; and the second meeting was held on May 5, 1847, in Philadelphia, when steps were taken to make the organization truly national in character. Physicians of New Jersey actively supported the national organization from the outset, and the minutes of the State Society of 1846 and years thereafter contain references to the A. M. A. regularly.

The interest of the physicians of New Jersey in the recent meetings of the A. M. A. has been surprisingly uniform, as is shown in the following table:

	1935	1937
Total Registration A. M. A.	8166	9764
Registration from New Jersey	967	1184
Per Cent from New Jersey	10.7	12.1
N. J. Speakers listed	6	10
N. J. Exhibitors	4	6

The number of members registering at the Annual Meetings of The Medical Society of New Jersey during the last four years has been as follows:

1934	549
1935	464
1936	582
1937	696

The registration of physicians from New York, New Jersey, and Pennsylvania at the 1937 A. M. A. meeting was as follows:

	Registration	Per Cent of Total Registration
New York	1930	19.7
Pennsylvania	2373	24.3
New Jersey	1184	12.1
	5487	56.2

These three States supplied over one-half of the total attendance. The next highest State on the list was Ohio with 438 registered. At the Kansas City meeting in 1936, the registration of these three States was as follows:

New York	243
Pennsylvania	128
New Jersey	38
	409

These three States supplied six per cent of the total attendance of 6824 at the 1936 session.

The representation of New Jersey physicians on the official programs of the A. M. A. has been small. In 1937, there were 694 speakers listed on the scientific programs, of whom only six were from New Jersey, while 128 were from New York, and eighty-two were from Pennsylvania.

In 1937, there were 290 exhibitors listed in the scientific exhibits, of whom six were from New Jersey, while thirty-six were credited to New York, and sixty-one to Pennsylvania.

One element in the difference in the records of the three States is the presence of medical schools and research laboratories in New York and Pennsylvania. The extremely creditable showing of New Jersey physicians in the scientific exhibits at their own Annual Meeting is evidence of the excellent research work done in New Jersey.

The House of Delegates of The Medical Society of New Jersey voted to refer two subjects to the House of Delegates of the American Medical Association.

HYGEIA

The first resolution called upon the A. M. A. to make an investigation into "Hygeia", as follows (Transactions, 1937, p. 48):

"An investigation into the conduct of the magazine Hygeia,—particularly to articles that prescribe for the laity, and into the methods employed by the business manager in circularizing the laity with literature designed to at least imply that Hygeia magazine will take the place of a medical adviser." (Transactions, 1937, p. 48.)

The A. M. A. House of Delegates referred this resolution to the Board of Trustees, which reported as follows (Jour., A. M. A., June 26, p. 2208):

"The Board would report that it has constantly endeavored to guard against the abuses recited in this resolution. It has ever been the policy of Hygeia to instruct the public in sound medical science, and particularly as to the value and importance of the physician in procuring suitable medical care. The Board is glad to take this opportunity to reiterate its policy in this respect."

This resolution was adopted by the House of Delegates of the A. M. A.

PURE FOOD AND DRUG ACT

The second resolution of the New Jersey House of Delegates was on the Pure Food and Drug Act, and was as follows (Transactions, 1937, p. 59):

"That The Medical Society of New Jersey reaffirm the actions of this body of the past three years in opposition to the permissive and pernicious features of the Copeland Food and Drug Bill; and instruct our Delegates to the approaching convention of the American Medical Association to bend their efforts to develop a constructive program in the American Medical Association toward preservation of the *mandatory* provisions and the distribution of responsibility of the Food and Drug Law of 1906."

The action of the A. M. A. Reference Committee on Legislation and Public Relations was as follows (Journal, June 26, 1937, p. 2219):

"With reference to the Resolution on Opposition to the Copeland Food and Drug Bill, introduced by Dr. Walt P. Conaway in behalf of The Medical Society of New Jersey, your Reference Committee recommends that the American Medical Association pledge its support to any movement looking toward the promotion of sound and effective legislation—Federal and State—for the protection of the public against fraud and deception in the manufacture, distribution, and sale of foods, drugs, prophylactic, diagnostic and therapeutic devices and cosmetics.

This resolution was adopted by the A. M. A. House of Delegates.

NEW JERSEY FELLOWS OF THE AMERICAN ACADEMY OF PEDIATRICS

A dinner meeting of the New Jersey Fellows of the American Academy of Pediatrics was held on Thursday, April 29th, 1937, in Haddon Hall, Atlantic City, at the close of the Annual Meeting of the Medical Society of New Jersey. Dr. Stanley Nichols, State Chairman, presided. Those present were: Drs. Brown, Nichols, Nickman, Stewart, Hummel, Krauss, Blanchard, Ripps, Joseph, Ash, Heyman, Murray, Panitch, Robbin, Rosenberg, Rothstein, Silver, Uhr, Levinsohn, Fine, Lathrop, Mark, Blaugrund, Wilkes, Mills, Degenhardt, Jennings, and Hohman, of Baltimore.

PEDIATRIC COURSES

Dr. Murray described the pediatric courses being given at four centers throughout the State, by outstanding professors of pediatrics. It is hoped next year to have two more centers. It is also planned to have a dentist give one lecture; and to include in the attendance nurses, dentists, and those interested in child health; and to make provision for printing and distributing the lectures.

PRACTICAL PROJECTS

Dr. Nichols spoke on "How the New Jersey Fellows of the A. A. P. Can Best Forward the Improvement of Child Health in New Jersey". The membership in American Academy of Pediatrics for New Jersey is now forty-seven, and several new men have applied for membership. This just about covers the total eligible men in New Jersey. It is imperative for every member to become identified with some field of Child Health activity in New Jersey in which he is interested. By forming special committees and developing specific plans for the improvement of child health in New Jersey, it will make the Academy members the authoritative body to inform all groups on child health. A list of sixteen committees was sent to each member with the request that he return his card with his preference for a committee indicated. These preferences were discussed by Dr. Nichols.

Dr. Ripps suggested "The Demonstration of Mantoux Testing in Institutions" for the information of those not familiar with this routine.

Dr. Krauss suggested "More Coöperation with the P.-T. A.", which is so intensely interested in the pre-school and school age child, and is a field of activity where much good could be accomplished.

Dr. Robbins spoke in favor of "Clinical Conferences" in which the men could present their problems and obtain the opinion of others.

SUBJECTS FOR PEDIATRIC PROGRAMS

Dr. Rosenberg, Chairman of the Program Committee, requested an opinion of the members as to the kind of program they desire.

Dr. Brown suggested a meeting at Soho devoted entirely to the subject of *contagion,* and to have a demonstration. He also suggested greater interest in the new-born, where the death rate is still very high.

Dr. Fine, Dr. Hyman, Dr. Degenhardt, Dr. Mills, and Dr. Jennings favored the *round-table* type of meeting.

It was suggested that men in charge of nurseries compile reports on the type of equipment as used in their hospitals. This data would be extremely interesting, and would furnish information which is very difficult to obtain.

Dr. Rosenberg asked if something could not be done to amalgamate the programs and activities of the New Jersey Fellows, and those of the Pediatric Section of the State Society.

Dr. Nichols announced that this plan would probably develop in time, but at present the American Academy of Pediatrics does not have any recognition of the part-time pediatrician, although there is enough room in the field of pediatrics for these part-time men; and the pediatric section of the State Society does take care of these men.

Dr. Wilkes suggested that, in the meetings of the county societies, certain limited subjects should be discussed, and definite conclusions arrived at. This aim could be effected by the members of the Academy who would bring up specific subjects, and focus the discussion on the subject under discussion.

Dr. Nickman suggested two other subjects for study—"Field of Allergy in Childhood", and "Premature Babies".

It was suggested to arrange to have a prominent man in some particular field lead the discussion on this subject at the meetings.

EDUCATING THE PUBLIC

Dr. Mark requested information on how to inform the public of a small locality on preventive practices in child health.

Dr. Nichols stated that the State Society Committee on Public Relations under Dr. Kler would contact the public for their education, while the Academy would furnish the material for publication.

Dr. Hummel spoke in favor of "score cards", which he regards as the best solution to the discussion of the day. He also spoke in favor of more discussion on "Infant Feeding", and suggested that infant feeding be put on the program.

The concensus of opinion of those present was that the Fellows should be prepared to give an afternoon and evening for a public meeting; and that panel discussion, or round table, preferably panel discussion, with some clinical material added, be the program arrangement adopted.

Dr. Nichols stated he would have the score card ready for discussion at the time of the next meeting.

SCHOOL PHYSICIANS

Dr. Silver, President of the New Jersey Association of School Physicians, suggested the establishment of standards for school physicians, and the insistence that only those physicians who meet these standards be eligible for positions as school physicians. We must educate the public that school health work is *valuable,* and that it should be in properly trained hands.

Dr. Nichols suggested that Dr. Silver keep in close touch with school development through the Secretary of the Academy of Pediatrics, Dr. Grulee, and bring reports on the developments as they take place for the endorsement of the American Academy of Pediatrics and the State Medical Society, both of which are necessary in preserving this relationship. The list of full-time and part-time pediatricians, as compiled by the State Medical Society, could be offered as the list of men meeting the standards set up for school work.

THE HOME-MAKERS' FORUM

A Home-Makers' Forum is the title of a three months' radio program sponsored by the Extension Service of the College of Agriculture of Rutgers University, as a part of its program of extension work in agriculture and home economics. The general subject is "Infant Care and Training". The special subjects of the program are as follows:

July 12—"Anticipating Parenthood"
Dr. Margaret E. Fries, New York Infirmary for Women and Children. (This talk only at 2:45 p. m.)

July 14—"The Doctor Keeps the Baby Well"
Dr. Julius Levy, New Jersey State Department of Health.

July 21—"Are You an Anxious Mother?"
Dr. Harry Silver, Bureau of Child Hygiene, Newark, N. J.

July 28—"Equipping the New Arrival"
Mrs. Gertrude L. McLaughlin, New Jersey State Department of Health.

August 4—"Give Him Sunlight and Freedom"
Dr. Maurice L. Ripps, Pediatrician, Elizabeth.

August 11—"Baby's First Two Weeks"
Dr. Harold Murray, New Jersey Division American Academy of Pediatrics.

August 18—"Weaning the Baby"
Dr. Stanley Nichols, New Jersey Medical Society.

August 25—"Guarding Against Infants' Diseases"
Dr. Ellis L. Smith, Essex County Hospital for Contagious Diseases.

September 1—"Socializing the Baby"
Winona Darrah, Monmouth County Social Service.

September 8—"What Do Babies Want?"
Dr. J. Quinter Holsopple, State Department of Institutions and Agencies.

September 15—"The Baby's Father"
Dr. Bruce B. Robinson, Board of Education, Newark.

September 22—"Does a Baby Need Discipline?"
Mrs. Jeanette A. Slatoff, New Jersey State Department of Health.

September 29—"Mental Tests for Babies"
Dr. Helen M. Richardson, Assistant Professor of Psychology, New Jersey College for Women.

These lectures will be broadcast over Station WOR, Wednesdays at 3:15 p. m. Copies of the talks may be obtained by addressing The Home-Makers' Forum, New Jersey College of Agriculture, New Brunswick, N. J. Questions will also be answered if they are sent to the Forum.

CONTACTS AND COMMENTS

The policy of The Medical Society of New Jersey to establish close contacts with allied organizations is exemplified by the participation of several physicians in the program of the three-day meeting of the *New Jersey Pharmaceutical Association* which was held on June 23-25 in the Ritz-Carlton, Atlantic City.

Dr. Robert Fischelis gave an account of the *Conference of Allied Medical Professions,* whose last annual meeting is reported in this Journal of January, 1937, page 51; and Mr. Henry D. Kehr, a member of the Conference, gave a report of the *Committee on Professional Relations* of the Pharmaceutical Association.

Dr. Chester I. Ulmer addressed the association on the subject, "Physicians, Patients, and Prescriptions".

Dr. Hilton S. Read, Chairman of the Welfare Committee of The Medical Society of New Jersey and President of the Atlantic County Medical Society, was the principal speaker at the Annual Dinner on the evening of Wednesday, June 23.

A hundred years ago every physician put up his own medicines, and his "Doctor Shop" was a village "Medical Center" such as was described in the Bulletin of the Bergen County Medical Society of December, 1937.

"The shop was a forum, health center, and club
For the rich, the poor, and the callow cub,—
A vaudeville stage for practical jokes,
The scene of many a clumsy hoax
Where the doctor played the hero's part
With kindly innocence and art.
He radioed the latest news
Of local crimes with baffling clews
While the 'Setters' told their expectations,
Their fears and doubts, and insinuations.
Deciding questions of mighty weight
Of home and business, church and State."

In many of its atractive features the Pharmaceutical Association is a glorified development of the "Old-time Country Doctor Shop".

The official report of the Transactions of the Annual Meeting of the House of Delegates, held on April 27-29, is issued as a supplement to this issue of The Journal. The supplement also contains a resumé of all the events and programs of the Annual Meeting, including the proceedings of the Annual Meeting of the Woman's Auxiliary. The Transactions are longer and more interesting than ever before, filling 104 pages. The "Reports" and the "Transactions" together are almost as large as the reading matter in three issues of the Journal.

The annual reports of the officers and committees of The Medical Society of New Jersey were printed in the April Journal, and constitute the principal subjects of discussion. These reports filled fifty-nine pages, and are to be considered as an integral part of the Transactions.

Preserve these reports and Transactions for continual reference, so that you may know the important work which "Organized Medicine" is doing in New Jersey.

Whether he realizes it or not, every practitioner of medicine is deeply concerned with the reports of the meeting of the Welfare Committee on June 27th, at which the principal type of discussion was "The Development of a National Medical Policy", based on the consideration of the same subject by the American Medical Association at its annual meeting on June 7-11 in Atlantic City. Read the report of the meeting on page 463 of this Journal.

This meeting of the Welfare Committee is of special significance at this time, for one of its purposes was to organize its component committees for this year's work. It has an added significance because of the growing response of the county societies to the suggestion that they organize their own committees after the pattern of the component committees of the Welfare Committee. Every member of a county committee is in effect a member of the State Welfare Committee, and is responsible for the participation of the local doctors in a "Local Health Policy", in which every doctor shall participate.

The American Public Health Association, 50 West 50th Street, New York, is sending invitations to physicians and other public health workers to participate in the "Gadget Show" which will be a part of the exhibits at its annual meeting, which will be held on October 5-8, 1937, in New York City. This feature was first adopted at the annual meeting of the

Association last year in Pasadena, California; and was a center of attraction and interest.

Every clever physician is constantly applying old devices to novel uses, and old methods to new conditions, as our grandmothers did with a hair pin. Executive Officer Wilkes suggests that a "Gadget Show" at the Annual Meeting of The Medical Society of New Jersey would be within the scope of its activities, and would have a practical value to physicians.

The Iowa State Medical Society held its 86th annual meeting on May 12-14, 1937, which was described in its State Journal of April, May and June. The Society is comparable with that of New Jersey. It has a membership of 2300, or about 75 per cent of the practicing physicians of the State. The Society is active and is doing excellent work. For several years it has promoted the care of the indigent by means of contracts made by county boards with the county medical societies, by which the treatments are given under assignments of physicians by the county societies. All the fees are paid into the treasuries of the county societies, which use the funds in carrying on their activities, so that the members do not have to pay any local dues.

This profusion of funds derived from public sources is similar to that of The Medical Society of New Jersey during the half-century 1816 to 1866, when the State Medical Society's examination of candidates for medical practice yielded fees sufficient to finance all the projects of the State Medical Society and even to pay the expenses of members attending the meetings (Transactions 1881, p. 101).

The physicians of two counties, Linn and Polk, operate medical-dental service bureaus similar to those in New Jersey. The center of population of Linn County is Cedar Rapids, with a population of over 50,000; and of Polk County is Des Moines, with a population of over 12,500. The bureaus are operating like those in New Jersey, and with seemingly equal success.

The Iowa Journal of June comments editorially on the need for a committee or group which has authority to act in the interim between the annual meetings, as do the Trustees of The Medical Society of New Jersey.

The list of officers and committeemen of the Iowa State Society fills page 146 of the April Journal. The personnel numbers about ninety physicians serving on about seventeen committees, whose minutes are published in the Journal from time to time.

The impression gained by reading the accounts of the annual meeting is that the Iowa State Medical Society is active and progressive, and is working along original lines that are very similar to those of New Jersey.

The summary of Fourth-of-July accidents in the United States, printed on page one of the New York Herald Tribune of July 6, is encouraging to the supporters of a sane holiday. Until a late hour on July 5 it seemed that not a single death had occurred, but late in the evening there came a report of the death of an eight-year-old girl in a hospital in Woonsocket, Rhode Island, because of burns when her dress caught fire from a "sparkler", generally considered safe.

In the hospitals of Manhattan and Bronx, New York City, 291 persons were treated for burns—none of a serious nature. This compares favorably with twice that number in 1936, and four times that of 1935.

Before the Fourth of July one newspaper commented on the causes of Fourth of July accidents, and named as a prominent cause the utterly foolish custom of throwing lighted firecrackers at automobiles and even into the bodies of the car. The Editor observed this on several instances—happily with no injuries, except to the nerves of the occupants, whose agitation was taken as a joke by the onlookers.

"Practical jokes" are near tragedies; but in this land of the free, how can they be prevented when the crowd laughs at the victims? We did not hear of a single arrest, or even a warning, given by the police to the offenders.

In contrast with the small number of fireworks accidents was the national record of 228 killed in automobile accidents during the holiday. Deaths by automobiles, drowning, and other so-called "accidents" totaled 384,—which was second only to that of 1931 when 486 died from accidents.

The record is confusing in regard to what happened in the A. M. A. meeting on July 7-11, regarding a "National Health Policy". Some of the confusion was a disagreement among the members of the House of Delegates as to what to do; and more was the result of obscurities in composing the reports of the committees. It is strange that thoughtful students differ radically in the interpretation of the resolutions. A few accurate cross-references in the reports in the A. M. A. Journal would go far toward making the record readable and understandable.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

July

20 Warren 27 Hunterdon

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

The *Cumberland County Medical Society* met on June 8th, in Ivy Manor Sanitorium, Bridgeton, with Dr. Leslie E. Myatt, President, presiding.

REPORT OF ANNUAL MEETING OF STATE SOCIETY

The Cumberland County Delegates to the Annual Meeting of The Medical Society of New Jersey gave a complimentary report on its program and events. Reports were also given on the success of the meeting of the American Medical Association in Atlantic City, June 7-11.

NEW MEMBER

Dr. Nicholas Edward Marchione, of Vineland, was elected to membership.

SCIENTIFIC

Dr. C. H. deT. Shivers, Atlantic City, addressed the society on "Prostatic Hypertrophy".

MIDDLESEX COUNTY

Charles H. Calvin, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on Wednesday evening, June 16th, 1937, at The Roosevelt Hospital, Metuchen, and was called to order by the President, John H. Rowland, M.D.

SCIENTIFIC

The scientific program consisted of addresses as follows:

1. The Early Recognition of Pulmonary Tuberculosis, by Dr. Harry J. White.
2. Pulmonary Cavitation—Pathologic Types, by Dr. Walter Grossman, Senior Resident Physician.
3. The Treatment of Tuberculous Pulmonary Cavitation, by Dr. Paul Geary, Attending Thoracic Surgeon.

The papers were discussed by Drs. Silk, Edward Klein, William Klein, London, Leonard, Dagenhart, Brown, Sherman and Meinzer.

CHILD HEALTH COMMITTEE

Dr. J. S. Uhr, Chairman Child Health Committee, asked that the following recommendations be considered:

1. Proclaim a *Health Day* in September, on which day every school will be addressed by a physician on preventive measures.

2. Conference with the President of the Woman's Auxiliary in an effort to make the women health-minded through cöoperation. Have the members make a census of all school children and preschool children to determine who has and who has not had preventive measures carried out.

3. Arrangements with a local radio station for talks by a member of the Medical Society.

4. Mass meeting devoted to all Parent Teachers' Associations in the city, and an address by a member of the Medical Society.

5. Favoring the establishing of an Isolation Hospital.

The above recommendations were put to vote and passed.

E. R. A. COMMITTEE

Dr. Fithian, Chairman of the E. R. A. Committee, reported the following action by Perth Amboy officials:

1. The Advisory Board of the Department of Public Assistance of Perth Amboy thinks it necessary and advisable that a *Medical Advisory Committee,* consisting of not less than five and not more than seven Perth Amboy physicians, be appointed and to serve voluntarily for a period of one year. The committee is to meet with the officials of the Department of Public Assistance, and act in an advisory capacity on all medical problems.

2. Routine Wassermanns shall be taken on all relief patients, and the treatment for venereal diseases shall be authorized for payment by the Department of Public Assistance at $1.00 per office visit.

It was moved and passed the above arrangement be adopted by other municipalities in Middlesex County.

TUBERCULOSIS COMMITTEE

Dr. Silk, Chairman of the Tuberculosis Committee, moved that mass tuberculin testing of high school age children be done by physicians who are members of the Middlesex County Medical Society, and selected by the local governing body which controls the funds provided for that purpose.

This motion was seconded and passed.

NEW MEMBERS

The following members, having been passed by the Membership Committee, were unanimously elected to membership.

To Full Member:

Dr. Benjamin Copleman of Perth Amboy.

To Associate Membership:

Dr. Irwin J. Fine of Perth Amboy.

Dr. James J. O'Connel of New Brunswick.

DUES

Dr. Rowland read a report prepared by the Treasurer, Dr. Marshall Smith, giving a list of members and associate members delinquent in dues. A committee is to be appointed by the President to investigate these deliquencies and to recommend proper action to be taken.

The meeting was adjourned for refreshments which were furnished by the hospital.

MONMOUTH COUNTY

O. R. Holters, M.D., F.A.C.S., Reporter

A meeting of the *Executive Committee* was held at the Fitkin Memorial Hospital, Neptune, on Monday evening, May 10th. President O. K. Parry presided. The following members were present: Doctors Magee, Moffat, Blaisdell, Kazmann, Nichols, Clark and Featherston.

TREATMENT OF WARDS OF THE COUNTY

Dr. Blaisdell, Chairman of the Economic Committee, brought up the subject of the treatment of patients who come under the Old Age Pension System and the State Board of Children's Guidance. It is a question whether these patients are the proper clinic material, or whether treatment should be given under a plan similar to the old Emergency Relief Administration set-up. The Executive Committee recommends to the members of the Medical Society that these people be treated on the following financial basis: Office Call $1.00, House Call $2.00, Specialist fee $2.50.

ALLOCATION OF HOSPITAL FUNDS

A discussion was held concerning the recommendation made by John L. Montgomery, county adjustor, to the Board of Freeholders for the appointment of a hospital administrator. Mr. Montgomery suggested the appointment of Dr. George O'Hanlon, superintendent of the Jersey City Medical Center. His duties would be to determine a policy to be followed in apportioning county financial aid to hospitals claiming deficits through charity patients. The consensus of oplnion of the members of the Executive Committee was that the Medical Society should take no action on the recommendation at this time.

On Wednesday evening, May 22nd, at 8:30 p. m., the *Monmouth County Medical Society* held the monthly meeting at the Molly Pitcher Hotel in Red Bank.

The meeting was presided over by Dr. O. K. Parry of Asbury Park and was execptionally well attended.

ACTIVITIES OF THE STATE SOCIETY

Dr. William G. Herrman, newly elected president of the State Society, gave the principal address of the evening. He described the various activities of the State Society and its tentative program for the coming year. He also announced a number of appointments to various commitees of the State Society.

PUBLICITY

Dr. J. H. Kler, of New Brunswick, Chairman of the State Public Relations Committee, gave an interesting discourse on the "Better Understanding, by the Laity, of the Work and Aims of the Medical Profession." He declared that a more active part must be played by the physician in the various activities of lay-medical groups, such as the Red Cross, Social Service Organizations, etc. He emphasized the fact that many medical members of such organizations will not sacrifice their time, and therefore we are held in ill repute; and such organizations regard this as a lack of interest.

He also suggested news releases of a medical character to the press, through our Committee on Public Relations, on such topics as will interest the laity.

VENEREAL CLINIC

Dr. Harvey Brown, of Freehold, gave a lengthy discussion of the difficulties they were having in establishing a venereal clinic in Freehold.

The meeting was adjourned about 11 p.m.

A. M. A. NOTES

A large group of Monmouth County doctors attended the National Convention of the A. M. A. at Atlantic City, and were present on the Tuesday night when Dr. William G. Herrman made his address of welcome to the convention.

Dr. Helen Upham, of Asbury Park, presided at several meetings, and also at a banquet given by the women doctors of the A. M. A.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

The annual meeting of the *Morris County Medical Society* was held Thursday evening, June 17th, at the Spring Brook Country Club in Morristown, following an afternoon golf tournament on the club course, with refreshments at the nineteenth hole, and with dinner and entertainment by a vocal and instrumental trio in the clubhouse at eight.

President Sherman indicated his reluctance to interfere with the obvious and permeating pleasures of the members and guests for the transaction of business, but permitted volition to yield to necessity.

ELECTION OF OFFICERS

With about eighty seated for dinner, the business of electing officers was consummated and resulted in the unanimous election of the recommendations of the Nominating Committee, as follows:

President, L. E. Williams, of Madison
Vice-President, H. M. Larson, of Morristown
Secretary, George J. Young, of Morristown
Treasurer, J. Henry Barrington, of Rockaway
Reporter, Marcus A. Curry, Greystone Park

Three additional members of the Executive Committee:

B. G. Sherman, Morristown
D. W. Teller, Jr., Morristown
T. S. Thomas, Morristown

Members of the House of Delegates of the State Society:

To serve till 1939—F. C. Bowers, Mendham

To serve till 1940—B. G. Sherman, Morristown
D. W. Teller, Morristown

Member of the Nominating Committee, State Society:

Bernard C. McMahon, Morristown

Alternate Delegates to State Society:

William K. Booth, Mendham
E. T. Carberry, Wharton
W. F. Costello, Dover
R. L. Gilbertson, Madison
J. H. Harrington, Rockaway
George J. Young, Morristown

Minutes of the previous meeting were read by the Secretary and approved, as was also the report of the Treasurer, which showed the finances to be in a flourishing condition.

Prizes were awarded as merited by the results of the golf tournament:

Dr. Plume, first prize as the best golfer, an office scale donated by Garrett Byrnes & Son, physicians' supplies, East Orange, N. J.

Dr. Nicoll, of Dover, and Dr. Melvin, of Greystone Park, tied for second prize, and in the draw Dr. Melvin won second, and third to Dr. Nicoll.

Drs. Christian, McElroy, Comeau and Gilbertson tied for low net score, and in the draw first prize went to Dr. Christian; second, Dr. Gilbertson, and third, Dr. Comeau.

"Kickers' Handicap"—Dr. Ryman, first; Dr. Forbes, second.

Ninth Hole, Closest to the Pin—Dr. Teskey, first; Dr. Talmage, second.

The ample and appetizing dinner in the clubhouse was enlivened by community singing and happy renditions by the entertaining trio.

MEDICAL FACILITIES IN Y. M. C. A. CAMP

Dr. Nicoll made a plea in behalf of "Morris Camp", Y. M. C. A., that the members look over their equipment, and that any instruments to be replaced or discarded be donated for the camp emergency room.

PRESIDENT'S ADDRESS

Retiring President Sherman reviewed the activities of the past year and stressed points of interest to the society. Newly elected President Williams expressed his appreciation of being chosen as President for the ensuing year and hoped that with the interest of the other officers and members next year will be as successful as the past.

ENTERTAINMENT

Various members and guests were invited to contribute to the enlivenment of the evening, which they did both facetiously and in practical trend: Dr. Larson recited what he called an epic poem on the "Ideal Life" of "Ira Jones" from his fundamental inception into this world to his end, all the while under the care and guidance of various members of the county society, and his recitation was most mirth producing. Others contributing were Drs. McElroy, Pinckney, Costello, who read an article on the appearance of Senator Lewis before the A. M. A. at Atlantic City recently and pointing to its significance; and Drs. Londrigan and Norton, who with Dr. Brennock and Dr. Granelli were present from Hudson County.

The incidents of the afternoon and evening were fundamentally based on freedom from cares and responsibilities, and on a general good time, and these aims and purposes were fully realized.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

A special meeting of the *Passaic County Medical Society* was held Tuesday, June 15th, 1937, at the Health Center, Paterson, at nine p. m., the President, Dr. Fred Vosburgh, presiding.

The following problems were considered:

1. The employment of an Executive Secretary.
2. Increase in society dues.
3. Cost of Cancer Exhibit.
4. Report of the Compensation Commission.
5. The approval of a Field Physician.

EXECUTIVE SECRETARY

First.—The employment of an Executive Secretary. After much discussion in which Drs. Willard, Wolfson, Dingman, Feiring, Shapiro and Johnson participated, a motion was made by Dr. MacMillan, seconded by Dr. Dingman, to empower the President and Executive Committee to employ a full-time Executive Secretary.

INCREASE IN DUES

Second.—The increase of dues. A motion was made by Dr. Roemer, and seconded by Dr. MacMillan, that the dues be increased from twenty, to twenty-five dollars a year. After some discussion by Drs. Yates, Joseph, Johnson, and MacBride, the motion was passed. A suggestion was also made that, if any members found it a hardship to pay the increase, it would be practical to pay it in installments.

CANCER EXHIBIT

It is planned to hold a three-day symposium and exhibit on cancer of the gastro-intestinal tract, with Dr. Louis Shapiro, of Paterson, Chairman of the committee. The dates are October 13-15, and the place will be either the Public Library, or the Central High School of Paterson. All hospitals in the county are participating, and individual members are asked to send material for the exhibits. One hundred dollars was voted by the society for defraying the initial cost of the exhibit.

COMPENSATION COMMITTEE

Fourth.—Report of the Compensation Commission. Dr. MacBride gave a short report that there were necessary changes in the Compensation Law to be made, and he suggested a committee of five to study the suggestions and to report back to the November meeting. This was moved by Dr. Feiring, and seconded by Dr. Roemer, and this motion was passed. Dr. Vosburgh then appointed Dr. Mac-

Bride Chairman and Drs. Ash, MacMillan, Spickers, and Feiring, as members of this committee.

FIELD PHYSICIAN

Fifth.—The approval of a Field Physician. It was moved by Dr. MacBride, and seconded by Dr. Willard that Dr. Graham be appointed as District Field Physician for Passaic County for Maternal Welfare and Child Health because of his fine work in this field. This motion was passed.

The meeting adjourned at ten-forty p. m.

UNION COUNTY

SUMMIT MEDICAL SOCIETY

E. H. Macpherson, M.D., Secretary

The *Summit Medical Society* held its annual meeting at Overlook Hospital on Tuesday evening, May 25th. The officers elected for the following year were: President, Dr. John D. Tidaback; Vice-President, Dr. W. J. Hallock; and Secretary-Treasurer, Dr. E. H. Macpherson. The Program Committee consists of Dr. N. W. Burritt and Dr. M. G. Bensley. Dr. John L. Meeker is the retiring President.

The speaker for the evening was Dr. Harold Pardee, of Cornell University, New York City, who spoke on the timely topic "Prognosis with Arteriosclerotic Heart Disease". He stated that this is a slowly progressive condition consisting of hardening of the blood vessels of the heart. He enumerated a large series of autopsies at the Mayo Clinic, where Dr. Willius found 40 per cent of the heart vessels changed without causing any symptoms to the patient. Dr. Pardee stated that high blood pressure does not exert a serious influence on this type of disease. He advised that persons suffering with this condition should avoid undue excitement, strenuous exertion, cold air, large quantities of cold liquids, and indigestion.

Thrombosis always occurs on an area of a thickened and calcified endothelial tissue. Ninety-three per cent of infarcts occur in the left ventricle with seven per cent in the right ventricle. When the systemic blood pressure changes, the coronary blood pressure follows a similar course. Arteriosclerotic heart disease is a slowly progressive condition with many persons remaining in the "occult stage" until inadequate coronary circulation gives rise to symptoms. As the result of vascular changes, murmurs may occur when the valves become impaired, a large heart may result, and an abnormal electrocardiograph may be found. There is no proof regarding the progress of a coronary disease. A physical rest merely aids the condition of lessening the demands of the circulatory system. The occurrence of cardiac failure is a serious complication, resulting in the extension of the pathology to the coronary vessels.

Regarding the treatment, Dr. Pardee administers aminophyllin gr. iii every three to five hours, in the acute and sub-acute cases; later he gives gr. iss t. i. d. He stated that its value is questionable. The patient must remain in bed for one month after the fever has subsided.

Following the meeting, a collation was served at the Nurses' Home.

LIST OF PHYSICIANS DYING IN NEW JERSEY IN MAY, 1937

Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Ambrose K. Brennan	66	May 24	Plainfield	Plainfield	Carcinoma of colon.
Lawrence Demarest	48	Jan. 14	U. S. Marine Hosp.	Englewood	Cholecystitis.
John B. Garrison	88	May 19	Hopewell	Same	Acute myocarditis.
Robert H. Phillips	71	May 10	Trenton	Same	Carcinoma of rectum.
George R. Pancoast	76	May 22	Palmyra	Same	Chronic myocarditis.
Alvin S. Rogers	47	May 23	Trenton	Same	Bacterial endocarditis.
John M. Summerill	85	May 14	Pennsgrove	Same	Decompensation of heart.

THE WOMAN'S AUXILIARY

WOMAN'S AUXILIARY EXHIBIT AT THE A. M. A.

By Mrs. Ily R. Beir, Atlantic City, N. J., Chairman

This description of the exhibits of the Woman's Auxiliary of the American Medical Association is printed for the purpose of suggesting projects which the County Auxiliaries of New Jersey might adopt in their year's work, and whose results they might show in an exhibit in the Annual Meeting in June.—Editor's note.

The purpose of the Exhibit Committee of the Woman's Auxiliary to the American Medical Association is to educate State and county auxiliaries in the branches of auxiliary activity, as outlined in the Auxiliary Handbook, and to show them, by exhibits of State work, what has been accomplished by some, so that all may benefit by study of the results and the methods used. It is not an exhibition of medical curiosities, instruments, etc.

During my incumbency, I have stressed the educational side and have tried to make the exhibition of this committee, during the annual convention of the Woman's Auxiliary to the A. M. A., a clearing house of Auxiliary accomplishments throughout the nation for review of the results of their efforts, by State and national officers.

The exhibits have been planned so as to present their lessons quickly and clearly to visitors, who have much to do and little time. That these plans have materialized this year was attested by an attendance and interest far greater than ever before, by the repeated return of visitors for further study of the exhibits, and by the serving, at the tea on June 9th, of three times the number of guests anticipated.

Instructions were given State exhibit chairmen to have their exhibits in the form of scrapbooks with indices attached; or posters, diagrams, illustrations, maps or examples of some special form of activity. The exhibits were as follows:

Scrapbooks containing details of Auxiliary happenings were sent by eleven States. The one from Arizona was most unusual and beautiful, being bound in board covers, held together by rawhide thongs; to the front cover was nailed a sheet of native virgin copper, embossed with a painted desert scene. Texas sent two scrap books with wooden covers fastened together by rawhide, on which were branded the symbols of various ranches.

Six States sent maps showing counties, which counties had Auxiliaries, and the gain, from year to year, in Auxiliaries and their memberships. Kentucky sent two maps: one showed the area of Louisville covered by last Spring's flood and the other outlined the flood area of the State and showed the measures carried on by Auxiliaries and other agencies in combating disease and in relief. These methods were illustrated by photos, pictures, etc., connected by colored yarn to the county Auxiliaries concerned.

Four States sent posters used in their work. Those of Utah and South Dakota were health hints. Minnesota sent four posters made by school children, in a State-wide contest, that illustrated the various types of work done by the county auxiliaries and the methods used. One consisted of many circles of crayon sketches, pasted to the cardboard, and self-explanatory or with printed descriptions, a marvelous creation.

Nine States sent special exhibits. The one from Illinois was a large cutout figure of a nurse bearing a scroll, upon which appeared the many activities of that State. It was mounted on a background, also cut out, and the colors were blue and gold.

Louisiana sent a cut-out representation of a school house, with school room and fixtures, showing their school work and the growth of Auxiliary activities and membership during the last ten years.

For New Jersey, we had the booklet (Jour., April, p. 306) gotten up by Mrs. A. G. Rogers, which outlined yearly programs of Auxiliary activities, and contained lists of State and county officers, memberships, etc.; examples of the Medical History work exhibited at our last State convention, and consisting of a photostat copy of the minutes of the first meeting of the New Jersey State Medical Society in 1766; a State medical license issued in 1826; exhibits of biographies and photos of Presidents and noted men of the State and county medical societies and of doctors in practice

fifty years or more; and genealogies of medical families with a doctor in three or more generations. These were shown by Atlantic, Camden, Essex, Monmouth, Passaic, and Union Counties.

New York had a very large exhibit of its Maternal Welfare work. Ten feet of wall space was used for posters, and a like amount of table space was occupied by a cut-out representation of a tenement, with walls, furniture, floors, and occupants shown in detail both before and after instruction and help in hygiene, prenatal and post delivery care. Pamphlets and nursing care were also exampled.

Oregon had an unique 4 x 5 foot sampler made of squares, each illustrating a famous and different trail to this State. On each was a description of the work done by the State committee making the square.

South Carolina sent a two-and-a-half-foot-palmetto, its State tree, with a pamphlet on the history of the State Auxiliary.

From Utah came its famous "Health Circus" made of up three circus rings, covered by a tent, and side shows. These depicted fights against bacterial, laws to control epidemics, fatty eats, cure-alls, reducers, rabies control, medical fakers, nostrums, food fads, cancer cures, and the doctor fighting all these. This display has been sent to medical conventions all over the Union.

Delaware sent a cellophane-wrapped seven-piece layette.

West Virginia had an exhibit using twenty feet of wall space, and consisting of a large sheet to which were fastened many types of surgical and maternity dressings made by one county; a book on the founders of the State Society; and two ten-foot black satin runners on which the hobbies of local doctors were caricatured by photos, sketches, and effigies made of pipe cleaners, etc.

Complete reports of the 1937 work of this committee will be published in the Quarterly News Letter of the National Auxiliary. As chairman of both the Exhibit Committee of the National Auxiliary and the State Art, Hobby and Medical History Committee, I hope I may have the coöperation of the chairmen of the other State committees in getting together a large exhibit of these activities for the 1938 National Convention.

Mrs. Ily R. Beir, *Chairman.*

Hudson County

Reported by Mrs. Joseph Murray

The regular monthly meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held on Monday, May 3rd, at the Y. W. C. A. in Jersey City at two p. m., the President, Mrs. A. E. Jaffin, presiding.

Mrs. Louis Dodson, Entertainment Chairman, reported that plans were being made for our annual Spring luncheon and card party to be held at the Ridgewood Country Club on May 26th at 12:30 p. m.

Mrs. Edward Waters, Recording Secretary, read a letter from Dr. Henry C. Barkhorn inviting the members of the Auxiliary to the Academy of Medicine of Northern New Jersey in Newark to hear an address by Dr. Max Danzis on May 20th, and by Dr. George Draper on May 27th at 8:45 p. m.

MEMORIAL SERVICE

Mrs. Frank Nicholson read a short memorial service to those members and others nearly related to the society who have passed away during the last two years. The members were Mrs. John Mooney, Mrs. James Enright, Mrs. Frank Haggerty and Mrs. John O'Neill. Others whose memory was honored included Miss Aleta Freile, Dr. John Nevin, Dr. John Ward, Dr. Joseph Binder, Dr. M. E. Flaherty and Miss Ada Fuller.

ANNUAL REPORTS

Annual reports were read by the Chairmen of all committees. Mrs. Miles T. Long, Membership Chairman, reported that during the last two years thirty-nine new members had joined the Auxiliary. The membership now totals 131 active members including eight honorary members.

PRESIDENT'S REPORT

Mrs. Jaffin then read her President's report, which is as follows:

"As retiring President, it becomes my duty to submit a report. It is not my intention, however, to dwell upon the actual work done during my term of office, for that has just been accomplished by each Chairman in reporting individually the splendid achievements of her own department. It is my purpose rather to report my personal activities and my observations of the Auxiliary as a whole.

"The Auxiliary has had a most interesting and encouraging two years of continuous activity; and whatever success has been obtained has been made possible through the eager coöperation of Past Presidents,—officers and members alike,—and the desire of all to share the responsibilities.

"Our Public Health Program has been an outstanding piece of constructive work. We have heard much about the awakening interest of the public in health matters. Some of us are intensely health conscious; and others have no interest at all in such matters. But the interest is growing, and at present seems to be keener and more alive than ever before. It was because of this interest and the objective of the Auxiliary to be a medium be-

tween the medical profession and the laity—that we first conceived the idea of the *Five-Minute Health Talks.* The approval of the Advisory Board was readily obtained, but securing the talks was another matter. Today, however, the American Medical Association, who at first turned down our request as impracticable, and then upon being pressed, reluctantly consented to furnish a few summations of their radio broadcasts, has taken up the idea, and are now publishing them in large quantities for other Auxiliaries throughout the country, for many have adopted the Hudson County plan of stressing preventive medicine. If twenty-two lay groups in our own county have deemed it worth while to take advantage of the service we have put at their disposal, providing either Health Talks or Speakers on Health, then we as doctors' wives ought to feel not only gratified but well rewarded for the great effort that has been put into the project. We are actually helping the Medical Society in their campagn to make the people of Hudson County health conscious,—one of the major aims of the Auxiliary.

"We owe much to Mrs. James Murphy and Mrs. Benjamin Macchia for their unfailing devotion and painstaking efforts in carrying through the detailed work of this project. Nor are we unmindful of the group of ladies serving as readers, who so diligently coöperated with their chairmen. We are grateful to them all.

"Our Educational Program, under the capable direction of our First Vice-President, has been varied and full of interest. A dependable worker, untiring and inspiring, it has been a real joy to work with her.

"Our Social Program, with many committee meetings and social affairs, has had a very able leader. We owe much, very much, to the perseverance and enthusiasm of Mrs. Louis Dodson, who with her associate, Mrs. Maras, and a group of eager assistants, has done so much to create opportunities for developing friendships and entertainment for all.

"We are proud of 'Entre Nous', proud of the ability and talent displayed by its editors and contributors. It was my happy privilege to hear our State Historian in her report at the recent annual convention praise it very highly, auguring great things for Hudson because of it. To the ladies who made secure the financial future of this pamphlet we are most thankful.

"No one has worked more faithfully, quietly and efficiently than our Press and Publicity Chairman, Mrs. Joseph Murray. Every detail of her department, and there are many, has been so competently executed, that at no time has Hudson County been found lagging in publicity for the State or county.

"A History of the Auxiliary from its inception is being compiled under difficulties by our Historian. But her executive ability promises us something very much worth while.

"The Library, a new venture, under the generous direction of our pioneer President, Mrs. Friele, has provided another bond of interest for the Auxiliary, as well as a small nucleus for augmenting the Treasury. The Refreshment Fund, carefully supervised by Mrs. Ruvane, provides a more interesting supplement than last year. The very recent idea of a Benevolent Fund for those of the medical profession has struck such a sympathetic note among the members that some substantial progress has already been made toward this objective. All these various funds have meant more work for the Treasurer, but as usual no task has seemed too great, and she carries on as cheerfully as ever.

"At last, but by no means least, I would speak of a member whose devotion and loyalty to the purposes and aims of the Auxiliary, to your President and to every member in the Auxiliary has been exceptional. Her sound judgment and advice have been so indispensable that no committee has been complete without her. To your President she has rendered two years of service beyond measure, and never to be forgotten. As Chairman of the Membership and Telephone Committee Mrs. Miles T. Long's activities for the Auxiliary have been numerous. She has been able to report some new members at every meeting; she has given of herself and her telephone most unselfishly. Of course her committee has been extremely faithful to her, and has made possible an unerring judgment of the amount of hospitality required for each meeting. We are greatly indebted to this committee for the very exacting service rendered.

"During the past year we have suffered the loss of two of our very active members. A most capable Corresponding Secretary, Mrs. Frank Haggerty was always ready and willing to render any aid she could in the affairs of the Auxiliary. Mrs. John O'Neil, though very much occupied by many other activities, still found time to represent the Auxiliary as a reader. We have missed them very much. The correspondence has been carried on by Mrs. Samuel Barishaw, who has given evidence of such efficiency that she has been called upon frequently for much beyond her official duties. Like our Recording Secretary, she has been faithful and loyal.

"The interest and coöperation of both Dr. Trugott Schuck last year and Dr. J. L. Evans this year, as Presidents of the Hudson County Medical Society, has been of great help and a stimulus to the Auxiliary. We ought to have more of it in the future.

"For the friendly spirit, coöperation and loyalty of those who have shared in the accomplishments of the year I am sincerely grateful.

"It is with mingled feelings of pleasure and regret that I now turn over the administration of the Auxiliary affairs to my successor. I can only wish her the same thoughtful consideration I have enjoyed, and for which I am deeply grateful to each member of the Auxiliary."

Following this report, Mrs. Frank Nicholson very graciously presented Mrs. Jaffin with the Past President's pin.

Mrs. Jaffin had the new officers conducted to the front of the room and presented the gavel to Mrs. Charles B. Kelley, the incoming President, who then presented a tea rose corsage to all the out-

going officers, chairmen of committees Past Presidents and new officers.

The new officers are:

Mrs. Charles B. Kelley, President
Mrs. Arthur O. Largay, President-Elect
Mrs. Ellis Chapman, First Vice-President
Mrs. Charles Tannert, Second Vice-President
Mrs. Andrew Ruoff, Recording Secretary
Mrs. Harry Perlberg, Treasurer

The meeting then adjourned, and tea was served by Mrs. J. Searle McDede and a group of hostesses.

There were forty-eight members present including two new members. The new members were Mrs. Archibald Olpp and Mrs. Samuel Schlept, of Union City, who also received a tea rose corsage from our very gracious President, Mrs. Jaffin.

Essex County

Reported by Mrs. Frank S. Forte

The Public Relations Committee of the *Woman's Auxiliary to the Essex County Medical Society* gave a tea on Monday, April 26th, 1937, at the Academy of Medicine in honor of the Presidents and Secretaries of various organizations throughout Essex County that are interested in health education. Mrs. Harry A. Schacter was hostess, assisted by Mrs. Don A. Epler, Mrs. William D. Minningham, Mrs. Frank S. Forte, Mrs. Gustave Brown, Mrs. Frank J. McCauley, Mrs. Joseph Skwirsky, Mrs. N. Del Deo, Mrs. Anthony Parisi, Mrs. R. J. Brady and Mrs. Joseph Echikson.

Mrs. George A. Rogers, State President, and Mrs. Fred Shoul, Essex President, poured. The lovely coffee urns purchased from the proceeds of Mrs. Don A. Epler's card party held on March 16th were put into good use at the tea.

Dr. John Bennett Morrison was guest speaker, and gave an interesting talk on socialized medicine and its bad effects.

A Board meeting was held at one p. m., and a business meeting at two p. m., preceding the speaking and the tea.

Dr. Edgar J. Ill was speaker and guest of honor at the annual luncheon and meeting of the *Woman's Auxiliary to the Essex County Medical Society* on Monday, May 24th, at L. Bamberger & Co. A birthday cake was presented to him, it being the tenth anniversary of the Auxiliary and Dr. Ill's recent birthday.

A history of the Medical Society's work for the Widows' and Orphans' Fund was given by Dr. Ill, who has served as the President of that fund for more than fifty years. The speaker told of the embarrassment of families of doctors when left without funds and their unwillingness to accept charity. The organization for widows and orphans has been meeting this need for many years, he pointed out, asking for additional membership.

He also said, "Relief coming from the fund can be received as a right and not a charity." The fund is created from membership dues and a small fixed assessment on members at the death of any member. Dr. Ill was introduced by Mrs. Theodor Teimer, Chairman of the fund in the State Auxiliary.

Mrs. Fred Shaul, of Bloomfield, retiring President, was presented with a President's Pin, the presentation being made by Mrs. Teimer.

Officers and Chairmen reporting were:

Treasurer, Mrs. S. H. Baldwin
Recording Secretary, Mrs. Anthony Ambrose
Public Relations, Mrs. Harry A. Schacter
Membership, Mrs. M. B. Weinstock
Social, Mrs. Don A. Epler
Cheer, and Widows' and Orphans' Fund, Mrs. W. D. Minningham
Corresponding Secretary, Mrs. John N. Pannullo
Publicity, Mrs. Frank S. Forte

New officers were installed as follows:

President, Mrs. Charles A. Rathgeber
President-Elect, Mrs. Gustave A. Braun
Vice-President, Mrs. Albert S. Harden
Recording Secretary, Mrs. John Young
Corresponding Secretary, Mrs. John N. Pannullo
Directors, Mrs. E. D. Newman, Mrs. Richard Staehle
Chairmen of Committees:
Hospitality, Mrs. Earl Snavely
Membership, Mrs. Don A. Epler
Public Relations, Mrs. Louis Schneider
Printing, Mrs. Clymont MacArthur
Widows and Orphans, Mrs. W. D. Minningham
Legislation, Mrs. Manfred Kraemer
Telephone, Mrs. Richard Staehle
Program, Mrs. J. Irving Fort
Press and Publicity, Mrs. S. D. Jessurun



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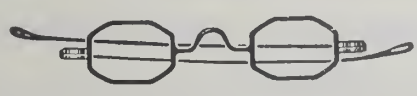
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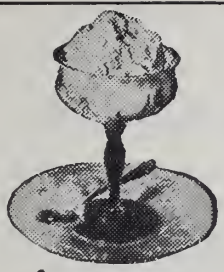
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	Parts per Million	Grains per U.S. Gallon
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Iron (Fe)	Trace	Trace
Aluminum (Al)	0.7	0.04
Manganese (Mn)	None	None
Calcium (Ca)	13.7	0.80
Magnesium (Mg)	5.8	0.34
Sodium (Na)	5.6	0.33
Potassium (K)	Trace	Trace
Bicarbonic Acid, Radical (HCO_3)	43.1	2.52
Carbonic Acid Free (CO_2)	7.0	0.41
Sulphuric Acid, Radical (SO_4)	27.1	1.58
Nitric Acid Radical (NO_3)	1.8	0.11
Chlorine	4.2	0.25
Phosphorus	Trace	Trace
TOTALS	128.9	7.54
Cubic centimeter N/10 Acid to neutralize one litre (methyl orange indicator)	7.06	
Hydrogen Ion concentration, pH		
As received	6.8	
After boiling	9.0	

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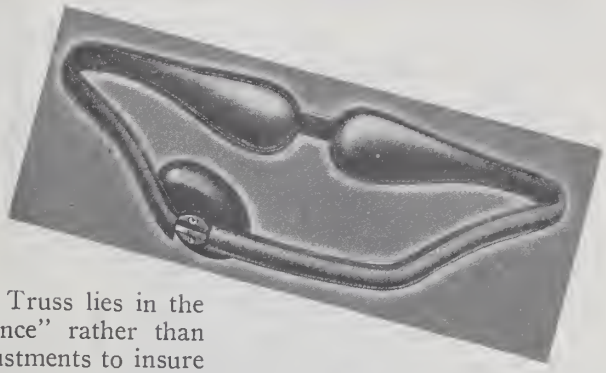
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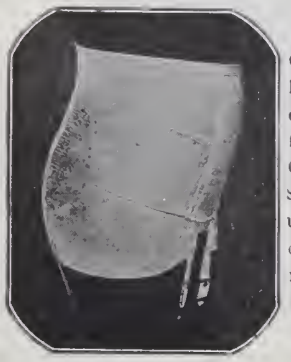
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1936	4,692	17.9
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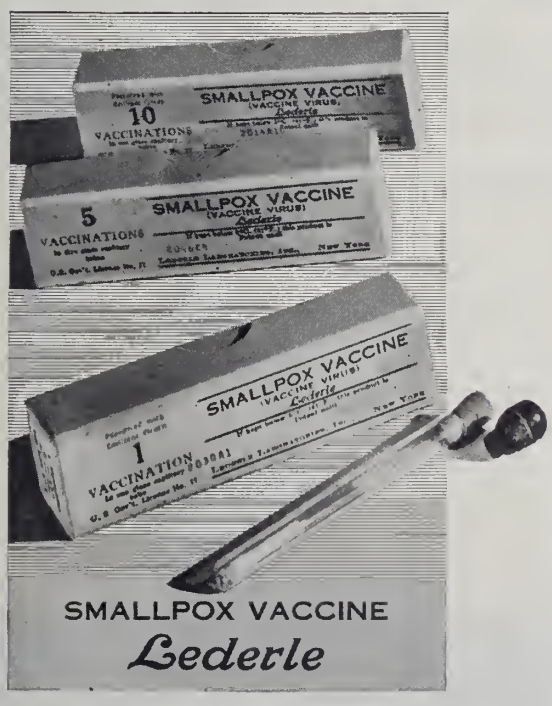
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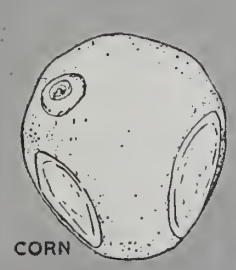
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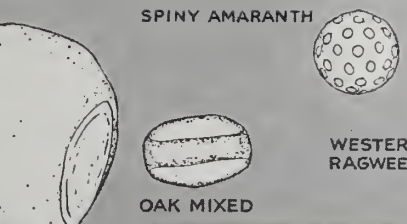
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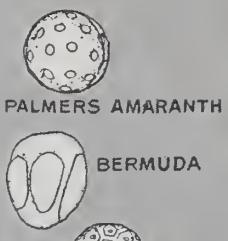
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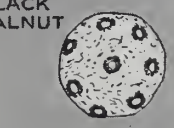
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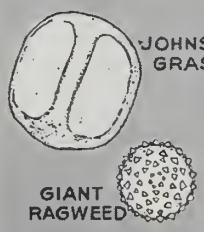
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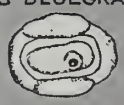






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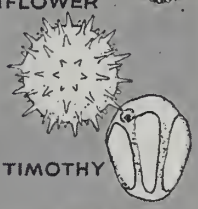


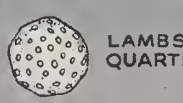
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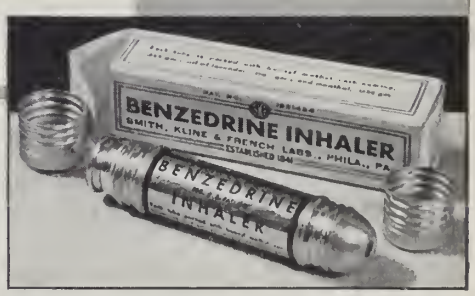
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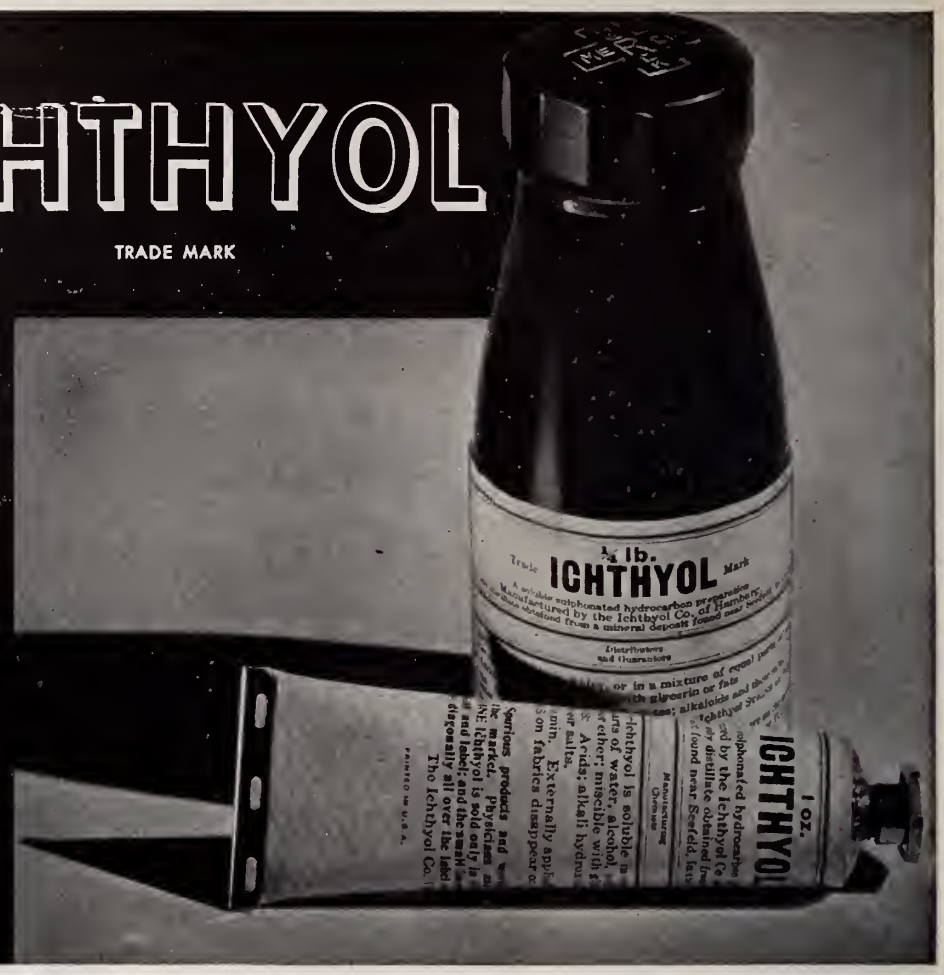
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PROTECTION OF VITAMIN C IN CANNED FOODS AGAINST ENZYMATIC DESTRUCTION

• One of the unusual features of modern food preservation by canning is the high degree of protection afforded vitamin C during the canning procedure. Of all the vitamins, C is probably the most readily destroyed. Spinach, for example, will lose one-half its vitamin C content upon standing three days at room temperature and practically all of its antiscorbutic potency in seven days' time (1).

Oxidation is the principal factor operating in the destruction of vitamin C. The rate of oxidation depends—among other things—upon temperature, degree of exposure to oxygen, and presence of substances which catalyze the oxidation reaction. Chief among the catalysts is the enzyme known as ascorbic acid oxidase. This enzyme is instrumental in the loss of physiologically active forms of cevitamic acid (ascorbic acid) by catalyzing the transformation of this latter substance into dehydrocevitamic acid (dehydroascorbic acid), which is more readily decomposed by a nonenzymic reaction into a compound having no antiscorbutic activity. This enzyme is apparently widely distributed in the vegetable kingdom, having been found in cabbage, carrots, lima beans, parsnips, peas, pumpkin, spinach, squash, string beans, sweet corn and swiss chard. Fortunately, the cevitamic acid oxidase is completely inactivated by heating to 100°C. for one minute (2).

In modern canning practice field crops are harvested at the optimum stage of maturity and canned as rapidly as possible—usually within a few hours' time. Early in every canning procedure the product receives either a blanch or a pre-cook or exhaust, the primary purpose of which is to drive out air from biological tissues and to establish a vacuum by expanding the contents of the can by heat, contraction upon cooling resulting in a partial vacuum within the can. These preliminary heat treatments together with the heat process serve both to destroy oxidative enzymes and to remove most of the air from the can.

Thus, the various practices in the canning procedure combine to afford excellent protection for this most labile accessory food factor known as vitamin C.

AMERICAN CAN COMPANY

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(1) 1936, Food Research, 1, 1

(2) 1936, J. Biol. Chem., 116, 717

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DIARRHEA

"the commonest ailment of infants in the summer months"

(HOLT AND McINTOSH: HOLT'S DISEASES OF INFANCY AND CHILDHOOD, 1933)

One of the outstanding features of DEXTRI-MALTOSE is its low fermentability and consequent preference in the management of infantile diarrhea.

In summer diarrhea, "The best food to use is boiled skimmed milk, acid skimmed milk, or dried protein milk. Carbohydrates are added in the form of dextri-maltose."—*G. Wiswell: Infant mortality and its prevention, Nova Scotia M. Bull., 15:504-509, Oct. 1936.*

—•—

Concerning the treatment of diarrhea, "If the weight remains stationary, it is an indication that loss of substance is occurring through the stools, mostly in the form of alkaline salts. To equalize this loss of substance, the diet must be increased, but in such a way as to avoid causing fermentation. This may be done by adding dextri-maltose and preparations of protein to the food, increasing the calories until the infant is taking 160 calories per kilo. of body weight."—*H. L. Ratnoff, Nutritional disturbances, Arch. Pediat., 41:771, Nov. 1924.*

—•—

"A very frequent cause of underfeeding results from the improper treatment of diarrhea . . . One of the greatest advances made in the science of infant feeding was the development of protein milk by Professor Finkelstein and the use of buttermilk or lactic acid mixtures. The great advantage of being able to feed the infant with fermentative diarrhea a food containing 12 calories to the ounce, like protein milk, after only one day on a starvation diet, is apparent. In addition, the further advantage of being able to safely add a carbohydrate like Dextri-Maltose No. 1 or No. 2 to the protein milk within a few days, enables one to gradually bring the infant up to its basal needs in a short time. When protein milk was first used, carbohydrate additions were advised against with the result that many children on it went into a state of collapse. The suggestion of Dr. Alan Brown of Toronto, Canada, that Dextri-Maltose be added to protein milk, was of great value."—*G. J. Feldstein: Underfeeding of infants and children, Arch. Pediat., 50:297-306, May 1933.*

—•—

Regarding the treatment of diarrhea, "In our experience, the most satisfactory carbohydrate for routine use is Mead's dextrimaltose No. 1."—*F. R. Taylor: "Summer Complaints," Southern Med. & Surg., pp. 555-559, Aug. 1927.*

—•—

"Again, following the teaching of the originator of protein milk, the carbohydrate added should be the one that is most easily assimilated. Dextri-maltose is the carbohydrate of choice."—*R. A. Strong: The diarrheas of early life, Mississippi Doctor, 14:9-15, Sept. 1936.*

"If the stools are acid, green, and excoriating, a food high in protein and low in fat, and carbohydrate is indicated. Dried powdered protein milk is very ideal here—one to ten dilution. On the other hand, if the evaenations are brown, watery, and stinking with putrefactive odors, a protcolytic diarrhea, it will be of advantage to add a small amount of carbohydrate, a dextrimaltose preparation being very efficacious."—*A. G. Dow: Diarrheas in infants, Nebraska M. J., 20:22-24, Jan. 1935.*

SERIOUSNESS OF DIARRHEA

There is a widespread opinion that, thanks to improved sanitation, infantile diarrhea is no longer of serious aspect. But Holt and McIntosh declare that diarrhea "is still a problem of the foremost importance, producing a number of deaths each year. . . ." Because dehydration is so often an insidious development even in mild cases, prompt and effective treatment is vital. Little states (Canad. Med. A. J. 13: 803, 1923), "There are cases on record where death has taken place within 24 hours of the time of onset of the first symptoms."

—•—

"After the preliminary short period of starvation, protein milk should be used. . . . When the diarrhea has been sufficiently checked, dextrimaltose may be added and gradually increased until from 4 to 6 tablespoons are being used."—*W. L. Denney: Acute nutritional disturbances of infancy, Univ. West. Ontario M. J., 2:192-137, April 1932.*

—•—

In diarrhea, "Carbohydrates, in the form of dextri-maltose, well cooked cereals or rice, usually can be handled without trouble."—*B. B. Jones: A discussion of some of the commoner types of infantile diarrhea, and the principles underlying the diets used in their treatment, Virginia M. Monthly, 55:413-415, Sept. 1928.*

In the treatment of dysentery, "As a useful supplement, Bessau's thick rice water with 1 to 5 per cent dextrimaltose may be used, or soy bean milk, which also may serve as main nourishment in the rare cases of hypersensitiveness to cow's milk."—*O. Willner: Dysentery, in The Practitioner's Library of Medicine & Surgery, D. Appleton-Century Co., Inc., New York, 1935, vol. 7, p. 371.*

—•—

In cases of diarrhea, "For the first day or so no sugar should be added to the milk. If the bowel movements improve carbohydrates may be added. This should be the one that is most easily assimilated, so dextri-maltose is the carbohydrate of choice."—*W. H. McCaslan: Summer diarrheas in infants and young children, J. M. A. Alabama, 1:278-282, Jan. 1932.*

—•—

"When there has been a tendency to looseness of the bowels, a form of sugar which ferments but slightly, such as dextrimaltose, may be employed."—*W. Sheldon: The artificial feeding of infants, Practitioner, 134: 415-428, April 1935.*

—•—

". . . I begin to add carbohydrates slowly, by replacing ¼ ounce Casec every two days with ¼ ounce of Dextri-Maltose, preferably Dextri-Maltose Number one. As a rule, this is tolerated. When one ounce of Dextri-Maltose is used, the Casec, of course, should be discontinued."—*J. W. Reed: The etiology and treatment of diarrhoeas of infancy, Virginia M. Monthly, 53:732-735, Feb. 1927.*

—•—

In treating chronic diarrhea, "You do not need to starve such patients, but you select a diet of dried protein milk with the addition of dextrimaltose given in small three-houriy feeds, or soured milk, or an ordinary half-cream dried milk, or a whey mixture."—*R. Hutchison: Lectures on Diseases of Children, ed. 7, William Wood & Co., Baltimore, 1936, pp. 26, 65, 71-72, 76.*

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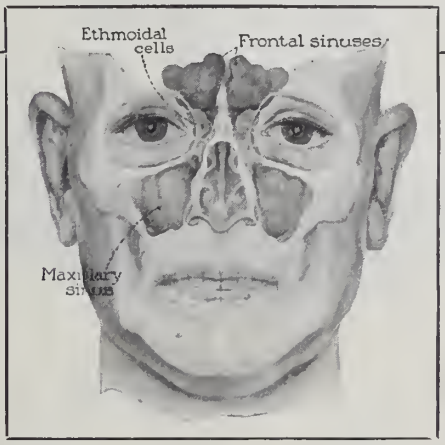
"The effect of a combination of dextrimaltose depends on the relative properties of the two components. If maltose is in excess, it tends to cause fermentation and loose stools, while dextrins are non-fermentable. In the preparations commonly used, Mead's Dextri-maltose Nos. 1 and 2, the maltose is only slightly in excess of the dextrins, and therefore they are advantageous if there is a tendency to excessive fermentation."—*W. J. Pearson and W. G. Wylie: Recent Advances in Diseases of Children, P. Blakiston's Sons & Co., Phila., 1930, pp. 74, 116.*

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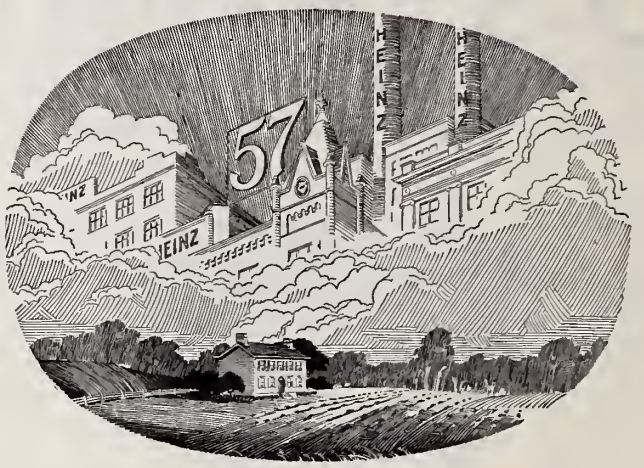
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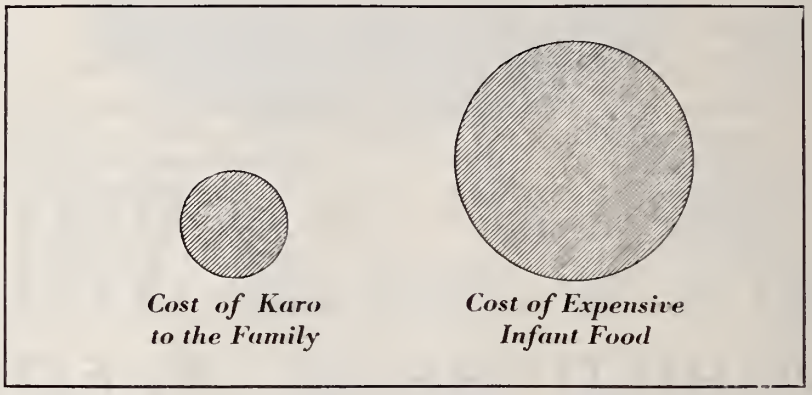
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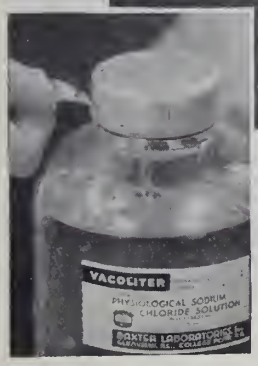


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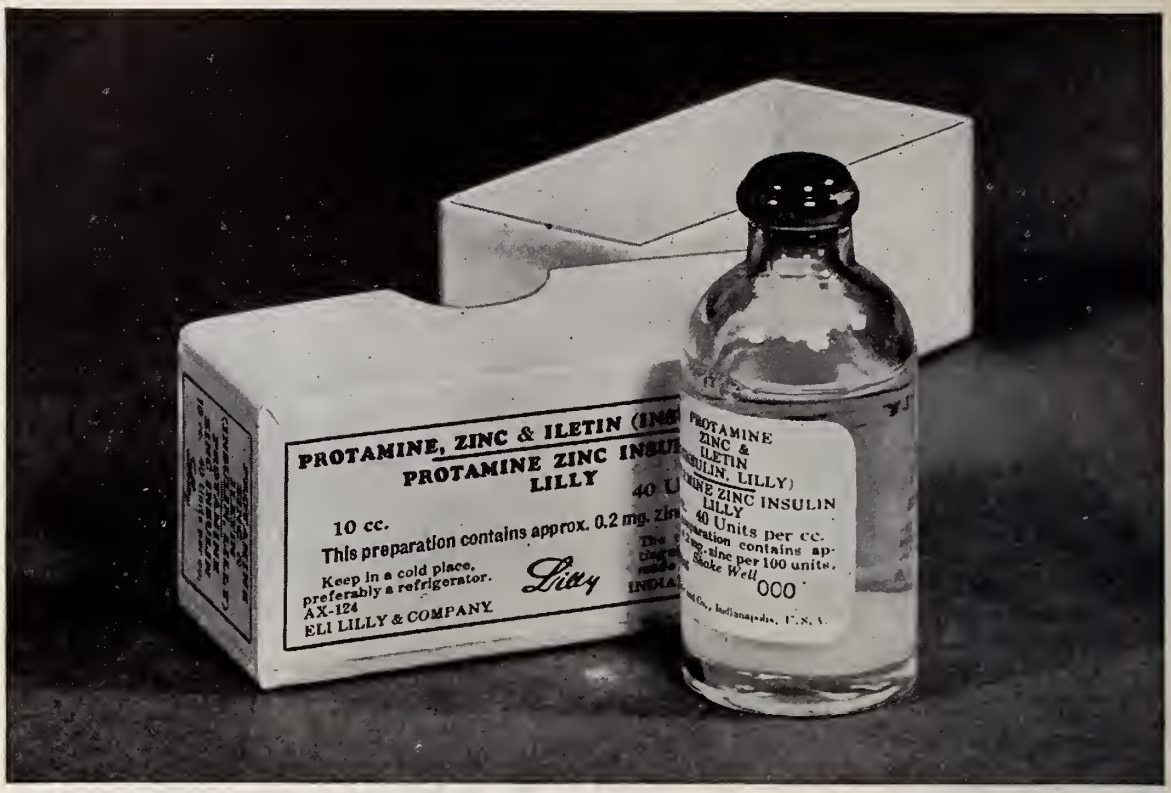
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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly

Under the
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Frank Overton, M.D., Dr. P.H.

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Executive Officer—LeRoy A. Wilkes, M.D.
Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. XXXIV, No. 8 August, 1937 Subscription, $3.00 per Year
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EDITORIALS

Midsummer Activities

The Medical Society of New Jersey is almost unique in its unwritten plan of action, which finds its highest expression in the unofficial "President's Cabinet". The Second Vice-President is chosen with the expectation that he will progress through the "chairs" of First Vice-President, and President-Elect to the Presidency. During the past years those in line of office have been "observers", but without special responsibility. Two years ago the sudden illness of the President created an emergency, which was met by the assignment of executive and supervisory duties to subordinate officers, thereby initiating them at once into the details of the duties which the Presidents had hitherto borne alone. The officers welcomed the opportunity to assume honorable responsibilities. They were inducted behind the scenes of action. They observed the medical needs of the State, and devised original methods of supplying those needs.

Last year the plan of the President's Cabinet, that was suggested from necessity, was made an integral, although unofficial, part of the executive machinery of The Medical Society of New Jersey. The result has been that each officer, as he was advanced in rank, was prepared for his duties after the plan of the United States Army in which each officer is compelled to prepare himself for the duties of the next higher grade.

The Annual Meeting had hardly closed last April when President Herrman and his Cabinet had their plans well formulated, based on the policies which had proved successful during the previous year. There is nothing novel or untried in their plans,—they are the evolution of previous experiences which have been described in the Journal in the current reports of the several committee meetings.

The unified plans of the thirty or more committees are outlined in the "President's Program" on page 520 of this Journal. The novel feature of the program is that each item is the plan of a chairman whose vision has been clarified by close contacts with the officers and members of the county societies during previous years.

The Field Physician

This Editorial is an informal statement of the principles by which the Field Physician shall act. His duties will be clearly defined officially when their scope becomes evident through experience.

Provision for a "Field Physician" in Maternal Welfare and Child Health for each county is an essential part of the service rendered by the Federal Government under the Social Security Act. The allocation of over $300,000 of the Social Security fund to New Jersey was necessarily accompanied by provision for supervising the expenditure of the funds, particularly those for improving the quality of service given by physicians.

The first proposal of the Federal Government officials was that their own officers would come into New Jersey and supervise the expenditure of these funds,—which meant that they would direct the doctors who rendered service to the patients in our state.

The representatives of The Medical Society of New Jersey objected to this method and offered the alternative plan that local physicians should be employed as Field Physicians, with safeguards acceptable to the Federal officials. The plan that was adopted by mutual agreement related to two major points:

1. The custody of Federal Funds.
2. The field supervision of the medical services.

FEDERAL FUNDS

The question of funds was solved by the Law that the State Department of Health should be the custodian of the funds, and the fiscal agent through whom the bills should be paid.

FIELD PHYSICIANS

The *supervision* of the medical work was debated, but was finally delegated to The Medical Society of New Jersey which recognized the need of supervision for two purposes:

1. To provide that the services rendered should be of high quality.
2. To provide prompt assistance to family physicians in difficult cases when the family cannot afford nursing and consulting services.

QUALIFICATIONS OF FIELD PHYSICIANS

It was first proposed that the Field Physicians should be able to teach family doctors how to practice obstetrics and pediatrics; but it was soon evident that the methods of a metropolitan hospital could not be applied in a rural community where the patient was miles from an institution, or a nurse, or a physician. The Field Physician is expected to secure help for a family physician, rather than to act as a specialist in any capacity.

An agreement was finally reached that the Field Physician should be an agent or liaison officer between the family doctor, and the professional or welfare groups which are prepared to assist the doctor with his patient.

It was further agreed that in his major qualifications he should:

1. Be a local physician in general practice, with general experience in maternal welfare and child health.
2. Have a temperament in which friendliness, optimism, common sense, and good judgment should predominate.

GENERAL DUTIES

The duties of the Field Physician will grow out of his contacts with the practicing physicians of his county. His knowledge and experience as a general practitioner will enable him to understand the problems of his medical brethren. He will approach the physicians from the sympathetic point of view of the Family Doctor, rather than that of the "Supervising" physician employed by an impersonal governmental bureau or endowed foundation that deals with masses rather than individuals.

PREPARATION OF THE FIELD PHYSICIAN

The Field Physician will prepare himself to be a source of information along the following lines:

A. *Standards of Action.* He will familiarize himself with the standard procedures that are described in three sources:

1. The Handbook of Preventive Procedures of the Family Doctor in the chapters on Maternal Welfare and Child Hygiene.

2. The reports of the Welfare Committee and its sub-committees and advisory committees that are printed in the Journal and the Annual Transactions of the House of Delegates.

3. Attendance at lectures to be arranged by various committees.

In these three sources he will find the standards which have been adopted and approved by his fellow practitioners after extensive experience in the private practice of medicine.

B. *Listing Local Health Organizations.* The Field Physician will secure a list of the following health organizations in his county, and make the acquaintance of their executive officers:

a. The Public Health Committees of his County Society.
b. Local health officers.
c. Baby Keep-Well Stations.
d. Public Health nursing organizations.
e. Tuberculosis societies.
f. Parent-Teacher Associations.
g. Hospitals and clinics.

C. *Statistics.* The Field Officer will study and be familiar with the statistics of his county in regard to maternal and child mortality. Practical charts and figures are being prepared for each county and will be published in the Journal from time to time.

It is essential that the Field Physician shall be familiar with the relative standing of his own county, as compared with that of other counties in the State. No county has a perfect record; but in every county there are cases of severe sickness which can be prevented by the means which are available locally.

SPECIFIC DUTIES

The specific work of the Field Physician will be *to call upon every physician in his county, and discuss the problems in maternal mortality and child hygiene which the doctor may meet.*

MATERNAL CARE

The Field Physician is authorized to discuss with the Family Doctor the following lines of Maternal Welfare:

a. Prenatal examinations and advice to the prospective mothers.

b. The facilities which are available or lacking for maternal and obstetrical care of individual patients.

c. The consultants whom the doctor may call in difficult cases of obstetrics. The Field Physician may authorize the Family Doctor to call any qualified consultant that he chooses; or in an emergency, the Family Doctor may call a consultant, provided he informs the Field Physician of his action promptly.

d. The Field Physician may authorize the Family Doctor to call a nurse under conditions similar to those applying to consultants.

It is the intent of the Social Security Law that every woman in labor shall have the services of a nurse, and a consultant physician if one is needed.

CHILD HYGIENE

The Field Physician is authorized to urge community agencies to supply assistance to mothers who are unable to provide the proper food, clothing, and housing conditions for their babies and young children. The services of consultants and nurses will be provided under conditions similar to those for the mothers in prenatal care and delivery. It is the intent of the Social Security Law that every baby and young child shall have all the care and attention which is necessary for its health and growth, especially those babies and children who suffer because of either financial need or ignorance on part of their parents. With his knowledge of the facilities which are available in the county and in the State, the Field Physician can send the proper consultant or nurse to the assistance of the Family Doctor. In every instance the Field Physician will act through the Family Doctor.

CRIPPLED CHILDREN

The Field Physician will be expected to pay particular attention to crippled children, and be prepared to advise the Family Doctor of the extensive facilities offered by the State for their care.

THE COUNTY MEDICAL SOCIETY

The Field Physician shall be active in his county society, and shall make regular reports to it concerning his work. The hearty coöpera-

tion of the County Medical Society is essential to the success of his work.

REMUNERATION

It is the intent of the Social Security Law that the Field Physician shall receive remuneration for his services. It is tentatively proposed that he shall work on an hourly basis, at the rate of approximately five dollars an hour.

It is tentatively estimated that in the smaller counties he shall give at least one hour a week to his specific duties, thus making his minimum remuneration at least $250 a year.

APPOINTMENT

The County Medical Society is charged with a particular duty in regard to the choice of a Field Physician. The plan adopted by the State Department of Health is that the society may nominate three of its members for the position, one of whom will be appointed by the Department. The requirement of three members being nominated is only fair, since this plan will preclude the possible charge of favoritism in the choice of an appointee.

The Secretary of every county society has been provided with blanks on which members may make their applications for the appointment. In every county society there are members who are qualified by experience and temperament to fill the position, to the honor and satisfaction of themselves, their associates, and the government officials.

Selling Costly Goods at Costly Prices

Any community living on the bank of a stream finds it necessary to reach the other side, either daily or occasionally. The stream must be spanned by a ferry, or a tunnel, or a bridge unless the inhabitants intend to swim back and forth.

If I were a bridge builder, my logical customers would be such a community. Without sales effort its people might be content with a ferry, or a pontoon bridge, or some other makeshift means of crossing; but if I were up to my job, I would survey the country and decide what communities needed their first bridge, or their second bridge, or their present bridge repaired. I would not sit back and wait for them to realize their need or to come to me; and then indifferently suggest the possibility that I might be induced to design a bridge for them. I or my sales department would interview a community that, we had discovered, needed our services; and by the time we were through with our sales effort, that community would be so sold on a new bridge, or an additional bridge, or the repair of a bridge, so completely that nothing would stand in their way of obtaining the goal of their ambitions. Furthermore, they would be completely sold on the idea that only my organization could design a bridge that would be entirely safe, would be economical in up-keep, would beautify their town, would enable them to visit neighboring territories, and would bring the customers they want to their market places. When they were so sold, they would be willing to issue bonds,—in other words to borrow money,—convinced that the expenses would be more than met by the increased revenue brought to the town by this bridge; or they would go out and convince their county, or their State, that the bridge entering their town would be of advantage to the larger section of the country that they were trying to interest.

They would not be concerned with obtaining the most economical bridge possible; they would not give up the idea of having a bridge unless they could get it for nothing. In other words, they would be willing to work for it, and to pay for it themselves.

We, as physicians, have costly services to render. The acquisition of skill and knowledge necessary to supply these services requires time and expenditure of money; and to render these services requires still more outlay.

Before we go further, let us have a clear understanding of what money is. Anything which is negotiable is not *material* wealth; it is merely *potential* material wealth. Only those things which you can touch, feel, or bite are material wealth. Those things that are directly negotiable are unused or stored-up human

energy; and so when we spend money, we are spending either our own effort or that of someone else. Gold has no value when it is in the earth. What gives it value is the amount of human energy to recover it and refine it. If anything is so plentiful or so easily obtained that it requires little human energy, we say it is cheap.

Medical services, therefore, are not cheap in the sense that they do not require an outlay of considerable human energy. Before any physician is capable of giving satisfactory medical care, he has had to outlay considerable effort of his own making, and also considerable human energy stored up by someone else. Just as the bridge builder has a costly article and service to sell, so also have we physicians.

We have been prodigal in our gift of care and attention to the poor and rich alike, and negligent in advertising our philanthropy. This is contrary to the custom of the financier who, when he gives up some of his stored-up energy in the bank, receives public acclaim through newspaper publicity. We have continued day in and day out to give costly services without requiring even a "thank you"; and large sections of the populace have come to believe that the philanthropic gift of the medical profession is rightfully theirs without expenditure on their part. For this we have only ourselves to blame. Therefore, if our costly gifts are appraised as cheap and common, it is because we have been so prodigal in our dispensing of them.

It is up to us, like the bridge builder, to correct this idea, and to make the people realize that the proper conservation and preservation of health are among the things worth while in life, and that these cannot be obtained without an outlay of human energy; i. e., money on the part of someone. If it is worth having or attaining, it is worth effort on their part. If they are incapable of effort on their own part, and obtain medical care free, they should then realize that it is a costly gift bestowed on them by the doctor with as much philanthropic spirit as any other public benefactor could exhibit. We must sell the public the idea of medical care as something so worth while that they must make every effort to acquire it; and if it is given to them, it is costly incense and myrrh for which they should be eternally grateful.

WILLIAM G. HERRMAN, *President.*

The Executive Offices

The Executive Offices of The Medical Society of New Jersey are the center for all the activities of organized medicine in the State. Here is assembled information concerning every phase of official medical society activities, both State and local, and from it there radiates a constant stream of information to the officers and committeemen of both the State Society and the component county societies.

The essential characteristic of the activities carried on in the Executive Offices is that of *friendly contacts* with not only the members of the State and County Societies, but with the leaders of other organizations having medical service among their implications. The services rendered are predominantly *personal.*

DIVISION OF WORK

The work in the Executive Offices naturally divides itself along two lines:

1. Executive.
2. Editorial.

These two functions were combined in one officer when the system was established in 1924; but in the Fall of 1933, they were divided between two persons, because the amount of work was too great for any one person to carry on with efficiency. The House of Delegates, at the last annual meeting, approved the employment of an Executive Assistant.

The executive and editorial work of the Executive Offices are mutually complementary. Success in their various lines of activity depends on the availability of their records. Re-

ports and records stored in cabinets are of little practical use; neither are they available when they are printed in full in The Journal. The work of the Editor consists largely in studying the field records, and abstracting them and rewriting them in the form of summaries. In doing this work the time of the Editor is as fully occupied as that of the Executive Officer in carrying on the activities originally. The result is that the records which the officers require in their work can nearly always be found in The Journal, without long searches in the files of isolated reports.

The essential characteristic of the functions of the Executive Offices is the team work of the Executive Officer and the Editor; and that of both with the members of the office staff. Everybody works in harmony with the others toward efficient coördination of effort.

COUNTY SOCIETY EXECUTIVE OFFICES

The next great item of progress in The Medical Society of New Jersey is the establishment of an executive office for each county society. Bergen County has had an Executive Officer for a number of years; Passaic has recently voted to employ one; Essex County is centralizing its work in connection with its Medical-Dental Service Bureau; Hudson County has its central office in the Medical Center; and some of the smaller county societies are planning to set up executive offices.

Over half of the county societies, including some of the smaller ones, publish their own *monthly bulletins,* by means of which every member is informed of the activities of his society. The facilities of the Executive Offices of the State Society are at the service of every county society that seeks them.

Dictatorship in Medical Policies

The New Deal in medicine is sponsored by great "Foundations" whose publicity agents are highly skilled in making "The worse appear the better reason." These foundations are canny enough to express their admiration for the highest kind of the practice of scientific medicine. Yet they do not lift a hand to promote scientific research such as that which is carried on by the Rockefeller Institute, and the great medical schools; nor do they promote courses in graduate instruction designed to enable practicing physicians to apply those principles in their daily work. They leave this work to be carried on by the Medical Societies of New Jersey, New York, and other States.

There was a time a few years ago when some of the great foundations made tentative approaches to State Medical Societies and offered funds to them to conduct their own demonstrations of methods of placing benefits of the practice of medicine within reach of the low-wage class of people; but the Medical Societies replied by quoting the ancient aphorism "Who pays the piper calls the dance."

When the administrators of the Federal Social Security Act offered a similar opportunity to the physicians of New Jersey last year, The Medical Society of New Jersey accepted the challenge and said, "We will draw up the plans and put them into operation provided you pay the bills." The representative leaders of the Medical Society asserted the principle "You work with us, rather than we work for you." This bold stand and its efficient results is an excellent illustration of what Dr. Herrman wrote in the July Journal, page 459:

> "Our Senators and Representatives in Washington want to represent their citizens. If they hear only from a certain class who are noisy and demanding, and all others remain silent, our Representatives can hardly be blamed if at times they misinterpret the wishes of their constituents."

Every act of The Medical Society of New Jersey is a demonstration of *Medical Democracy* in distinction from *Medical Dictatorship.*

The promotors of the federalization of our social and economic life in any phase, ride the advancing crest of a great wave of dictatorship which dashes upon the shore and soon retreats leaving destruction behind. The medical profession of New Jersey advances on a welling tide of concerted action which deepens the existing channels and bears its load of medical service to safe centers of distribution.

ORIGINAL ARTICLES

THE IMPORTANCE OF CLINICAL AND RADIOLOGICAL EXAMINATIONS OF THE GALL-BLADDER

By Henry C. Crossfield, A.B., M.D., F.A.C.P.
Assistant Attending Physician, Orange Memorial Hospital
and
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Radiologist, Orange Memorial Hospital

Read before the Radiological Section of The Medical Society of New Jersey at the Annual Meeting, June 4, 1936, in Atlantic City.

The importance of examination of the gall-bladder was well stated by Lyons in the first issue of the American Journal of Digestive Diseases and Nutrition in 1934. To quote:

"Owing to the enormous amount of research upon this subject that has occurred during the last twenty-five years, it is now more generally accepted that disease of the gall-bladder or of some part of the biliary system is more responsible for the occurrence of various symptoms of indigestion than is any other intraäbdominal organ or disease picture, not excluding appendicitis, gastric or duodenal ulcer, colitis, or intraäbdominal cancer. At times it can symptomatically mimic them all. Moreover, it can also mimic cardiac diseases or coronary artery disease, and when both are present it is often difficult to decide which is more responsible for the abdominal, chest, and back pains. Therefore, the gall-bladder should be studied in all cases of dyspepsia."

First we will consider history, physical examination and non-surgical drainage.

HISTORY

The importance of good histories of all cases and of all systems has been universally emphasized. In this particular group of cases the usual large variety of symptoms were present and will be enumerated later. As stated previously, the symptoms oftentimes simulate many other conditions. Symptoms such as jaundice, constipation, clay-colored stools, and localized tenderness which are generally associated with typical gall-bladder attacks occurred in a relatively small proportion of these cases. This would indicate that in the case of a chronic disease of the gall-bladder other symptoms are more frequently found. Most frequently the complaints are so indefinite that they merely *suggest* gall-bladder disease, heart disease, or some other local involved organ.

PHYSICAL EXAMINATION

Physical examination too often is of little positive aid. Localized tenderness is probably the most reliable positive finding, but this is seldom present in the early cases. In one unusual case of this group being reported, M. G., No. 21687, had pain when lying on right side. At operation the gall-bladder was densely adherent to the duodenum, transverse colon, liver, and omentum. But generally speaking, the great triad is history, non-surgical drainage, and radiological examination; and if any two are positive, there seems little doubt of the diagnosis. To be sure, physical examination frequently does have value in excluding other diseases and in the case of heart disease, especially so when augmented by electrocardiogram.

Among other common conditions which may cause gas and bloating are certain infections in the pelvis such as prostatitis or local rectal conditions. Because of this, it seems especially advisable to do a thorough rectal and pelvic examination on these cases.

Non-surgical drainage requires a very definite technic, and should be done only by one with experience, and preferably with the aid of a fluoroscope. The method and tube described by Twiss [1] has proved satisfactory in our hands. The tendency to routine, or at least more frequent, use of non-surgical drainage is quite apparent.[2] Few doubt its value as a diagnostic aid. There appear to be a greater num-

ber of advocates of non-surgical drainage as a method of treatment each year. We seem to be at the beginning of the second cycle, since we all remember, that when it was first introduced, it was recommended as a method of treatment. It is unnecessary to go into the merits of such treatment in this paper.

Gall-bladder surgery is in ill repute in the minds of some of the laity. This should not be so; and it has been our experience that, if more careful examination, including the examination of the bile, is done before surgery is recommended, the patient is more convinced of the necessity for such a procedure.

The microscopic examination of biliary drainage material, while not simple, can be done if one has given it sufficient study. Certainly, the characteristic cholesterol crystals and calcium bilirubinate crystals when bile stained, in the presence of considerable pus, seem to indicate the presence of stones.

The unfortunate results in those cases where pain persists after the removal of gall-bladder with stones might be avoided if earlier diagnoses were made. It is in those cases which have progressed to the stage where either cirrhosis of the liver or secondary changes have taken place in the biliary system with possibly further stone formation that the patient fails to get relief. This is assuming that good surgical technic was followed. When this is explained to the patient, the wisdom of earlier treatment is understood.

CASE 1

Miss B. D., aged 25, complained of fatigue, nausea in strange surroundings, occasional scotomata for the past two or three months. Past history irrelevant except for adenotonsillectomy at five years, and diphtheria when quite small. Menstruation normal. Family history: Father died of tuberculosis four years ago. The patient never takes any exercises, otherwise habits are good.

Present illness began about six to eight months ago, at which time she was given various tonics. Her chief concern is that, when friends visit her, or she is in any strange situation, she becomes nauseated and lifeless.

Physical examination revealed a well-developed, healthy looking girl. Sinuses clear. Teeth negative for apical infection. Pharynx negative. Neck negative. Thyroid not palpable. Lungs showed no abnormal impairment or râles. Apices clear and only slight peribronchial infiltration. Heart sounds normal. Blood pressure 100/60. Pulse 68. Orthodiagram normal, greatest diameter being 54 per cent of the chest diameter.

Abdomen revealed no tenderness or abnormal amount of gas. Barium meal showed esophagus not deviated. Stomach: of the fish-hook type, active peristalsis, emptied promptly. No deformity found.

Extremities negative. Urine essentially normal. Sedimentation rate (Westergreen method) one hour 11.5 mm., 22 hours 53 mm. (normal). Differential: polymorphonuclears 71 per cent, small lymphocytes 25 per cent, large lymphocytes 4 per cent, transitionals 2 per cent, red blood cells normal in appearance. Hemoglobin 82 per cent (Salhi). Basal metabolism rate minus 21 per cent. Wassermann negative.

Patient was given thyroid extract, grains one, twice daily and improved considerably. However, after two or three weeks she had a recurrence of her nausea and weakness when excited. Roentgenological examination of the gall-bladder was next made, revealing faint shadows suggesting the presence of non-opaque stones. Concentration of the dye was rather faint, but the gall-bladder was visualized. Two hours after the fat meal the gall-bladder appeared empty. Non-surgical drainage done according to the technic mentioned above revealed a thick bile with much mucus, many calcium bilirubinate crystals—bile-stained—in the presence of scattered pus cells. This seemed to confirm the additional diagnosis of chronic cholecystitis made by roentgenological examination. This was interesting because of the presence of the hypothyroidism, and is presented as an illustration of a case with minor symptoms and real pathology present. Feldman and Morrison [3] reported a group of cases having excessive amounts of thick mucus in the bile, in the absence of stones, which obtained relief by repeated drainage without surgical intervention.

In just such cases and in many others, it is necessary to have all the information possible for the institution of the correct treatment.

We are using the oral method of administering the dye in all cases. Very rarely is it necessary to make a second examination. The dye used is Keraphen, B-heavy, which is manufactured by Picker X-Ray Corporation. We have not tried the intravenous method, nor the intensified methods which are advocated by Stewart, Illick,[5] and others. For the past year and a half we have been using the 14, 16, and 20-hour intervals according to the technic of Dr. Kirklin of the Mayo Clinic.

Diseases of the gall-bladder and bile ducts,[4] which was published in 1928 by Graham, Cole, Copher and Moore, is still an authority on these diseases. There have been some refinements

in the technic of making examinations of the gall-bladder since this book was published.

According to the above publication, there are seven cholecystographic criteria of the pathological biliary tract which are in the order of their importance:

1. Non-visualization of the gall-bladder
2. Faint visualization of the gall-bladder
3. Delay in the appearance of the gall-bladder
4. Deformity in the gall-bladder
   - A. Congenital
   - B. Acquired
     1. Intrinsic
     2. Extrinsic, pericholecystitis
5. Cholelithiasis
6. Persistance of the gall-bladder shadow
7. Excessive size of the gall-bladder

These criteria have stood the test of time and are in widespread recognition.

STUDY OF A SERIES OF CASES

Our paper is based upon radiographic examinations of 1250 cases at the Orange Memorial Hospital from 1928 to 1935 inclusive. Of these cases, 1152 were examined with dye, and 98 without. Only 14 of these necessitated a re-examination, and eight of these were in the deformed group. Of these cases, 560 were reported pathological, 183 were operated upon and had their diagnoses confirmed, 50 of which did not have a pathological report. Four cases were reported normal radiographically and were found to be pathological when operated upon. Nine were reported pathological, and on operating the surgeon found a normal appearing gall-bladder. Four of these were pathological by microscopy, three others were not. (Films of two of these cases have been lost.)

The following is a summary of the 560 cases that were reported as pathological:

According to our radiographical diagnoses, the largest group was that of *non-visualization*. There were 192 of these, and 63 came to operation. The next largest group was 141 cases of stones, and 48 came to operation. Deformity was shown in 128 cases, 39 of which came to operation. There were 97 in the enlarged group and slow-emptying group, and 27 came to operation. In the faint visualization group there were 23 cases and five came to operation. There was one adenoma which came to operation.

There were 436 females; the youngest examined was 14 years, the youngest operated 16 years. The oldest examined was 81 years, and the oldest operated was 79 years. There were 124 males; the youngest examined was 14 years, who was operated. The oldest examined was 81 years, and the oldest operated was 70 years.

A study of the symptoms shows that pain was the predominating one and found in 66 per cent of the cases. Gas was found in 30 per cent. Nausea was found in 25 per cent. Vomiting was found in 20 per cent. Indigestion was found in 15 per cent. Jaundice, constipation, clay-colored stools, localized tenderness were found in 10 per cent. Halitosis was found in 25 cases. There were about 50 cardiacs, and 20 rheumatics in this series. Malignancy in the abdomen and chest were found in six of these cases.

SUMMARY

1. The accuracy of the diagnosis by radiological examinations with the oral method of the Graham test is again substantiated.

2. The variability of the symptoms present in gall-bladder disease is demonstrated, and indicates the great necessity of a very careful history and physical examination.

3. Furthermore, at least in doubtful cases, non-surgical drainage should likewise be done.

4. The additional information obtained from proper history, physical and non-surgical examinations is invaluable in obtaining the best information for outlining the proper treatment.

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A COMBINATION ARTHRODESIS AND SUB-TROCHANTERIC OSTEOTOMY OF THE HIP WITH A NEW TECHNIC OF ARTHRODESIS

By Henry Briggs, M.D., Newark, New Jersey

From the New Jersey Orthopaedic Hospital and Dispensary, Orange, N. J. Presented before the Society of Surgeons of New Jersey on May 20, 1936.

In two painful hip conditions, one of tuberculosis and one of Otto pelvis, each presenting a flexion adduction deformity, the author has performed a simplified arthrodesing operation, followed by an immediate sub-trochanteric osteotomy, with gratifying results.

OPERATIVE TECHNIC

The hip joint is approached through the Smith-Petersen incision, which exposes the ilium, the joint capsule, and the greater trochanter. The capsule is incised parallel to the neck; and with a sub-periosteal dissector and knife, the superior rim of the acetabulum, the femoral neck, and the base of the greater trochanter are cleaned of soft tissue.

With a broad ostetome directed from before backwards, a straight bed for a graft is prepared that starts at the base of the greater trochanter, passes through the superior aspect of the neck, making a flat surface of spongy bone, and across the femoral head and the rim of the acetabulum into the ilium making a notch.

A roughly quadrangular piece of ilium is removed above the notch sufficiently long to bridge the prepared bed, and is inserted spongy-side toward the neck so that one end is wedged into the notch of the ilium and the other into the greater trochanter. Bone chips from the ilium are packed above and around the graft.

The reflected periosteum and muscular flap is then sutured to its original attachment as far forward as the anterior superior spine, where it is securely anchored with a double chronic suture.

Then a sub-trochanteric osteotomy is performed. This may be a straight transverse section; preferably a curved osteotomy after Brackett or Albee should be used.

When the osteotomy is completed, the leg is put into the desired position, and the tissues closed in layers.

A double plaster spica is applied. This is left on about three months when a short single spica is applied and walking started.

CASE 1

*A. L., a white woman of thirty-one years of age, who was seen three times in June, 1933, when she complained of pain in the right hip of several years' duration. Examination showed spasm of the right hip, marked atrophy of the leg, flattening of the buttock, and marked crepitation of the knee. X-rays showed "destruction of the right hip with perforation of the acetabulum".



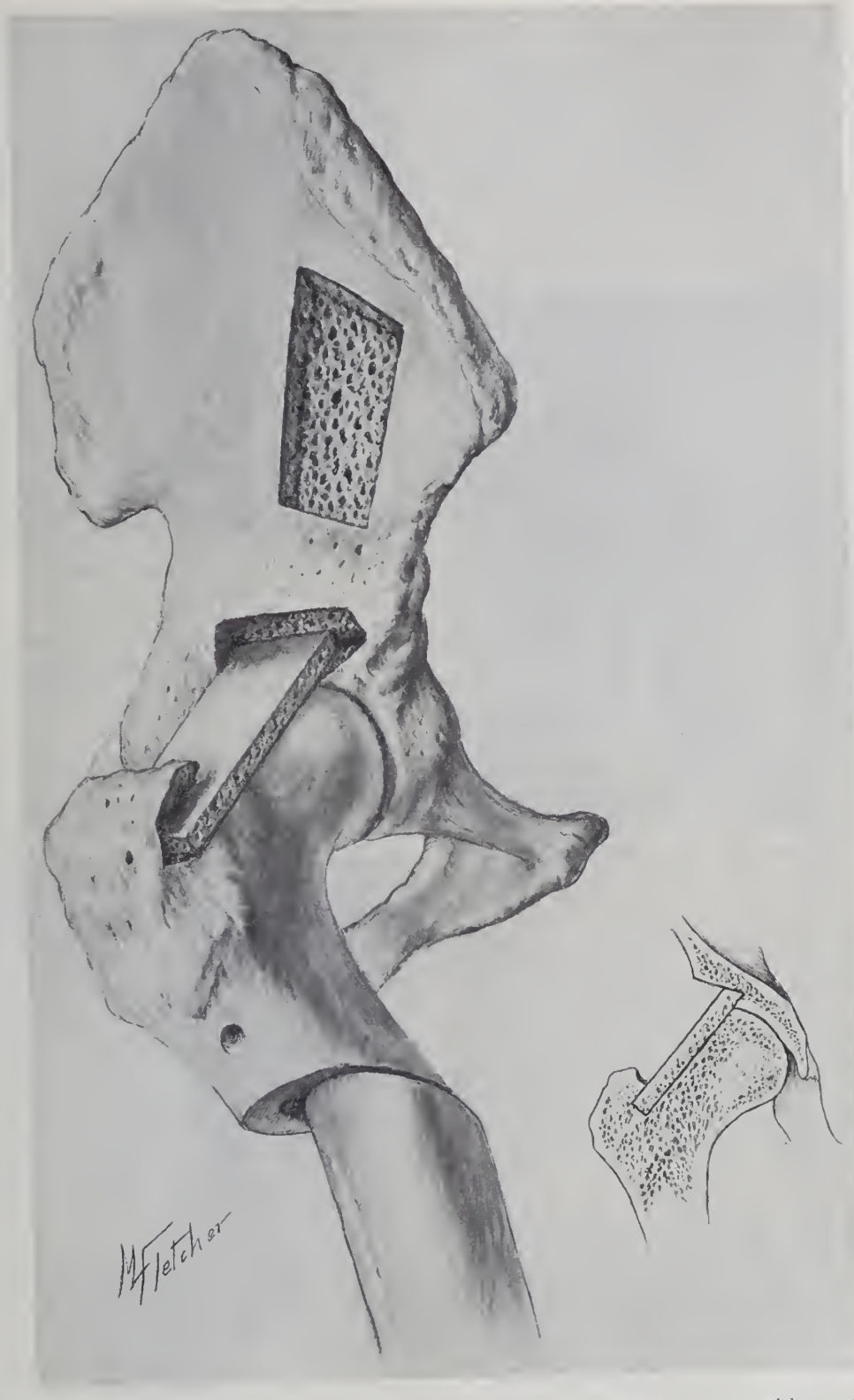
Case 1.—May 11, 1935. Intrapelvic protrusion of the right acetabulum. Before operation.

An unsuccessful attempt was made to aspirate the hip joint, and a Wassermann was reported negative.

She was next seen in May of 1935, and gave a

*This case has been reported as an example of Otto pelvis by our former resident, Dr. I. Francis Gregory, of Bangor, Maine.

Gregory, I. Francis: Report of Case of Surgical Treatment of Intrapelvic Protrusion of the Acetabulum. J. M. Soc. N. J., 33:23-25, Jan. 1936.



A drawing of Dr. Briggs' operation combining sub-trochanteric osteotomy with a new technic of arthrodesis.

history of trouble starting fourteen years before when falling out of bed after childbirth. At this time she stated that in 1923 a cast was applied and worn a year, and that she had no further trouble until a month ago, when severe pains started again running from the hip to the popliteal space.

Examination showed marked limitation of motion in the right thigh, with a flexion deformity of 45 degrees, and an adduction deformity of 30 degrees with atrophy of the thigh and leg, and a limitation of motion of the right knee in flexion.

X-rays are reproduced. A diagnosis of intrapelvic protrusion of the acetabulum was made.



Case 1.—November 18, 1935. Intrapelvic protrusion of the right acetabulum. After operation.

She was operated on July 19, 1935, by the author. The spica was bivalved on October 2nd, a short spica applied, and walking started.

The short spica was removed on November 3rd; and she went home November 10th. She received treatment in the clinic up to March 17, 1936.

In May she stated that she had no pain, and walked and even danced. Examination showed solid union. The position of the leg showed somewhat excessive abduction, and slightly too much external rotation, but could be considered satisfactory.

CASE 2

C. H., a white woman, twenty-nine years of age, was referred to the hospital by Dr. A. H. Groeschel, of Sussex, New Jersey. She complained of pain in the right hip region of four months' duration that prevented her walking and kept her awake at night. She had a long history of hip disease starting at the age of nine and continuing with constant trouble, including the incision and drainage of abscesses, the wearing of plaster casts, and the use of crutches to the age of fourteen.

Thereafter she had no trouble until after the



Case 2.—April 2, 1935. Old tuberculosis of the right hip. Before operation.

birth of her second child, when her leg began to get shorter. Shortly thereafter, in October, 1934, she started having constant pain, and ran some fever. The lungs were examined in February, 1934, and found to be not diseased.

In June, 1935, as her pain became worse, and her temperature higher, a plaster spica was applied. In August, 1935, this was re-applied without relief, and it was found she was constantly losing weight.



Case 2.—May 13, 1936. Old tuberculosis of the right hip. After operation.

On September 11, 1935, at the New Jersey Orthopaedic Hospital, examination of the right hip showed an adduction deformity of 45 degrees, and a flexion deformity of 45 degrees, with a few degrees of painful motion. There was some swelling in the gluteal region, but no fluctuation.

X-rays are reproduced. The diagnosis of old tuberculosis was made, and an operation advised.

She was operated upon on September 17, 1935, in the Alexander Linn Hospital in Sussex by the author. The plaster was bivalved on December 18, 1935, a short spica applied and walking started. She was discharged on December 21, 1935, wearing a short spica, which was kept on for about three weeks.

In May, 1936, she stated that she had no pain or discomfort in the hip at all, and was very pleased with the result of the operation. Examination showed that the hip was solidly fused; about 20 degrees of abduction and 20 degrees of flexion were present. Her back had well compensated for the altered position, and she walked well with some limp. There was a shortening of that leg of about two inches, for which she wore an elevated heel. The result was very satisfactory.

COMMENTS

This procedure is rapid and simple, because on one hand abduction and decreased flexion is not obtained by excavating the acetabular roof and shaving the femoral head and neck but by osteotomy; and on the other hand, time-consuming methods of obtaining firm fixation at the arthrodesis site are not necessary, because the position of the hip is not changed at operation, because the iliac graft acts as a stabilizing force, and because the osteotomy itself prevents motion of the proximal fragment by leverage from below until the consolidation of the arthrodes is well advanced. The author believes that this last factor in obtaining a rapid and strong fusion should not be under-estimated, but its relative importance can only be determined by further experience.

SUMMARY

1. A new technic for arthrodesis of the hip has been presented, combined with an immediate sub-trochanteric osteotomy to correct the deformity.

2. It is suggested that the osteotomy may be an important factor in obtaining a fusion by immobilizing the site of the arthrodesis.

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BOOK REVIEW

CLINICAL ENDOCRINOLOGY, by Samuel Loewenberg, M.D., F.A.C.P., Philadelphia, Pa.; 194 illustrations; thirty-seven tables and charts. Octavo, 852 pages; cloth; $8.00; 1937.

This large volume on the intricate subject of *Endocrinology* is written in clear style by a man whose clinical observations in large hospitals of Philadelphia equip him to write with complete authority. The volume is thoroughly modern and represents the knowledge available up to the time of publication.

The author is not opinionated or over-positive; he presents both sides of controversial questions in a fair way, and then summarizes all the knowledge in which endocrinologists are in agreement. There are very practical suggestions for treatment of endocrine disorders.

This book can be a whole post-graduate course in endocrinology for a really earnest doctor. The illustrations and the style of the text should make him master of the clinical phases of the subject. The usual handicap one meets in studying endocrinology is finding enough clinical cases. Dr. Loewenberg's book is a fair substitute.

A typical chapter chosen at random illustrates the valuable material in this book. The thymus gland is completely described as to its anatomy, and relations to other structures, and with a very careful analysis of its histology, and physiology. The author answers the controversial questions regarding the gland's actually being an endocrine organ, its essentialness to life, its connection with calcification, and influence on growth by quoting from the work of the most famous workers on each phase. He describes the work with thymus extracts and dessicated thymus gland. He summarizes the ambiguity of all this work by clearly stating the positive things in which endocrinologists agree. Then the author goes into the pathology of diseases of thymic origin in a most comprehensive manner, and finally suggests both prophylactic and active therapeutic measures. The style followed in the chapter on thymus gland is typical of the other chapters.

D. E. O.

FURTHER OBSERVATIONS ON THE OPERATIVE TREATMENT OF RETINAL DETACHMENT

By B. F. Baer, Jr., M.D., Philadelphia, Pa., and
J. S. Shipman, M.D., Camden, N. J.

Read before the Section on the Eye, Ear, Nose and Throat, at the Annual Meeting of The Medical Society of New Jersey, in Atlantic City, June 4, 1936.

In a previous article in the Pennsylvania Medical Journal, April, 1935, we disucssed the history of retinal detachment operations and the reasons which led to the adoption of the electrocoagulation method as described by Safar and Walker. At that time we gave in detail the preoperative study and preparation of our cases, with a description of the operative technic followed. The postoperative care with special reference to the use of pinhole goggles was also discussed.

In the above-mentioned article we reported twenty-two consecutive cases of retinal detachment which had been operated, and summarized our results. These were suffiicently encouraging to cause us to continue the same technic upon subsequent cases.

Professor Lindner visited the Wills Hospital in March, 1935, and taught us how to accurately localize the retinal tear with the ophthalmoscope and the Arruga spoon. Since then his technic has been followed, and found most efficacious. We have also found the Arruga spoon to be an excellent retractor which gives a much better exposure for the application of the micro pins in the sclera.

In this communication we are giving a follow-up report on the first twenty-two cases reported, and the results obtained in a series of twenty-two additional cases.

All of the cases reported were consecutive and unselected. Most of the cases were from the clinic of the senior author, and the others were private. All were done by one or the other of the writers, or by both. In all of these cases the electrocoagulation method of either Safar or Walker was used.

A brief summary of the salient facts in each case is given in the charts on pages 496-498.

CONCLUSIONS

When it is realized, that before the development of the operation for retinal detachment, this condition was a 100 per cent loss; the salvage of 45.4 per cent of these eyes is a triumph in the field of ophthalmology.

A number of our cases were in patients already blind in the other eye, and to these the success of the operation meant everything.

These cases have been reported with the hope that the results will stimulate other ophthalmologists to give their retinal detachment cases a chance by operation.

DISCUSSION

EDMUND B. SPEATH, M.D., PHILADELPHIA, PA.

This subject, the treatment of retinal detachment, is still very much in a state of general uncertainty. To this, all must agree. The uncertainty is not a matter of the advisability of surgery,—but instead any indecision is due to the many different methods for treatment being presented. More about this later. In the face of such an evident truth, a very few weeks ago, the statement was made to me by a man, whom all of us either know, or know of, that "95 per cent of retinal detachment should be recoverable". If we compare this with the prognosis of retinal detachment as it existed ten years ago as just mentioned by Dr. Shipman, we must agree upon a marked reversal of percentages in these prognosis possibilities. It seems as if the day is not far off when such a statement as that just given will be sustained.

The various etiological factors which are at fault in retinal detachment are being slowly but steadily uncovered, and at the same time, they are being sorted out into a true sequence of their relative importance. These must be known before therapy can be intelligently outlined.

Myopia of varying degrees with possible changes in the scleral coat appears in most series of cases (as in Dr. Shipman's), with an incidence of from 50 to 60 per cent,—an incidence far out of proportion to that one could find in any other group of ocular conditions. While it may not be a cause,—only an accompaniment,—still we want to know this with more certainty.

Uveitis is undoubtedly an important factor. Here, also, this condition has preceded the detachment in a percentage of cases much in excess of mere co-

incidence. Further, the development of recurrent uveitic phenomena are almost the rule in those cases wherein failures result following detachment surgery. Everyone has seen cataracta complicata develop in such instances, as the mildest of the iridocyclitic and uveitic sequelae.

A post-operative uveitis is certainly the principal etiological factor in detachment with aphakia. Just recently this has been impressed upon my mind so emphatically that there can be little if any doubt as to the correctness of the statement. Two recent cases of cataract extraction, after a stormy convalescence finally quieted to respectively, 6/6, and 6/9 vision. Each of them, within six months, developed retinal detachment.

The recent work of Lindner, and of others, in regard to the rôle which a *pathological vitreous body* plays in retinal detachment is quite consistent with that which we have just said relative to uveitis. Also, it is highly probably in consideration of the microscopic anatomy of the vitreous body and of the retina. There is a strong likelihood that a vitreous body contraction is the result of the earlier uveitis. Certainly the pathology which we have seen in the vitreous body, as the result of a long standing chronic uveitis, allows us to consider vitreous contraction, with subsequent traction upon the damaged retina as a great possibility.

Other facts connected with these cases are now upon a fairly well established basis. The rôle of the *retinal tear* in detachment and the urgent necessity for sealing this, are such, though the method of the formation or development of the tear is still undetermined.

Lastly there are other factors that appear in many isolated cases relative to which we are still much in doubt. Trauma is one of these, for repeatedly we see varying degrees of trauma quite inconsistent with the amount of detachment they have apparently produced.

The toxins of nephritis and of pregnancy are others,—for detachment is not at all uncommon during the course of such general systemic conditions. In fact, detachment during the progress of the latter of the two conditions was one that even in the "Middle Ages of Detachment Surgery" had a fair prognosis. Repeatedly we have seen retinal vascular pathology with retinal detachment as if some indefinite hydrostatic or mechanical basis existed. Still, ocular hypertension, as well as ocular hypotension (non-cyclitic) are strangely free from retinal detachment. Experimentally this has been repeatedly demonstrated. The men who have worked with retinal detachment surgery must have appreciated these indeterminate and often intangible features of the condition for they could not have advanced, as they did, along the various diverging lines in surgical therapy unless this was present. Coppez, Gonin, Larsson, Lindner, Quist, Safár, Sourdelle, Verhoeff, Vogt, Walker and Weve, are names which will stand high in the annals of ophthalmology whenever this subject is discussed.

Dr. Shipman has begged us to consider our cases from the start as surgical problems. This is so positive a fact that it needs no further qualification. One more thing, however, is of equal importance, and that is the necessity for studying each individual case exhaustively before we do operate. The literature is full, but often books published today are obsolete tomorrow, and methods presented tomorrow will be discarded shortly afterwards. Out of this maze and welter, however, standardized methods are slowly appearing,—each one of which seems to apply best to an individual case under consideration. For instance,—aphakia with detachment, seems to respond best to Larsson's technic of superficial electro-coagulation. The two cases mentioned above were corrected by this method.

Certain cases appear which still seem to lend themselves well to Gonin's original thermo-cautery puncture, especially those with large ragged peripheral tears.

Dubois and Amsler have written exhaustively relative to the importance of absolute exactness in the surface localization of retinal tears. This rather important fact, it seems to me, was one of the reasons why Vogt persisted in the perfection of his recently presented cathode-electrolysis method of treating retinal detachment; for it enables one to treat with absolute certainty any retinal tear which can be seen with the ophthalmoscope. Hence, cases with reorganized tears, especially when these are multiple, can be treated by cathode electrolysis under the full view of an ophthalmoscope.

Walker's micro-needles of iridoplatinum were a tremendous advance in the instrumentation necessary for successful detachment surgery. The use of his technic as he outlined it, while not a cure-all, will be justified by the results obtained in many instances. Macular tears and macular detachment are no longer hopeless since Lindner described his method of subchoroidal undermining, from the periphery toward the macula, and following this with the infiltration of a weak hydroxide solution into the tunnel thus formed.

To summarize, the speaker showed us result which prove without a doubt that retinal detachment is a surgical condition; that it is in many instances curable; and that the degree of recovery is to a large extent proportionate to the rapidity with which this condition is treated after its formation. We see in it nothing but happiness for us, and also for our patients in being the means of saving and restoring to them a function which so often is the very life of the patient and of his dependents.

All of us are indebted to the authors of this paper for their frank presentation of a serious ophthalmological problem. Their paper illustrates well the necessity for similar critical surveys so that we at large can sooner learn from their experience; for it is the only way to insure the number of successful results we should be turning out.

Case No.	Age	Sex	Vision and Approximate Refraction	Duration of Detachment	Retinal Tears	History of Injury	Type and Number of Operations	Results
1	18	M	5/60 —5.00 Sph.	3 mos.	None	None	Safar 1-14-33	Recovery—Retina in place. Field full V. 6/12, 3-12-36.
2	51	M	H. M. temp. side. High myope.	10 days	None	None	M. T. 3-21-33. M. T. & Weve needles 4-18-33.	Slight improvement. V. 6/60, 5-17-34
3	33	M	3/60 High myope.	5 days	None	None	M. T. 3-21-33	Recovery—Retina in place. Field full. V. 6/9, 4-16-36.
4	38	M	6/9 Emmetropic	1 week	Yes	None	M. T. 4-25-33.	Failure, 6-6-33.
5	52	M	6/60 No glasses	5 weeks	None	4 months previously	M. T. & Weve needles 5-13-33.	Failure, 6-6-33.
6	28	M	6/60 No glasses	3 mos.	None	None	M. T. 8-1-33.	Unimproved. V. 6/60, 8-19-34.
7	49	M	6/60 High myope.	2 mos.	None	None	M. T. 9-16-33. Safar 12-16-33. Safar 3-20-34.	Unimproved. V. 5/60, 5-2-36.
8	49	M	6/60 High myope.	1 year	None	None	Safar 9-30-33.	Recovery—Retina in place. Field full. V. 6/15 cc, 5-2-36.
9	48	M	2/60 low myope	11 days	None	1 month previously	Safar 12-16-33.	Recovery—Retina in place. Field full. V. 6/12 cc, 4-10-34.
10	55	M	1/60 high myope	1 week	Yes	None	Safar 1-6-34.	Recovery—Retina in place. Field full. V. 6/12 cc, 5-7-36.
11	29	F	2/60 high mope. Part. ambly.	2 days	Yes	None	Safar 2-3-34.	Recovery—Retina in place. Field full. V. 6/30, 4-16-36.
12	79	M	1/60 low myope	6 weeks	None	None	Safar 2-6-34.	Unimproved. L. P. only, 6-6-34.
13	55	M	F. 1 m. Aphakic	3 weeks	None	Cat. oper. 7 mos. before	Safar 2-15-34. Safar 3-4-34.	Retina in place. Field improved. V. 6/12 cc, 5-18-36. F. 1 m., 3-20-34.
14	48	F	6/60 low myope	3 weeks	None	Fall 1 mo. before	Safar 3-28-34.	V. 6/12, 4-28-34. Redetachment. V. 6/60, 5-26-34.
15	38	F	F. 1½ ft. No glasses	1 year	None	None	Safar 3-31-34	Improved slightly. V. 1/60, 4-24-34.
16	50	F	3/60 Mod. myope	6 weeks	Yes	None	Safar 5-2-34.	Recovery—Retina in place. Field full. V. 6/9, 4-9-36.

Case No.	Age	Sex	Vision and Approximate Refraction	Duration of Detachment	Retinal Tears	History of Injury	Type and Number of Operations	Results
17	56	M	H. M. Mod. myope.	6 mos.	None	None	Safar 5-26-34. Walker 7-2-34.	Improved slightly. V. 2/60, 8-21-34.
18	68	M	H. M. 2½ ft. High hyp.	1 year	None	None	Walker 5-29-34. Safar 6-26-34.	Improved. V. 6/60, 8-25-34.
19	60	M	H. M. High myope	1 year	None	None	Walker 6-12-34. Walker 7-31-34.	Recovery—Retina in place. Temp. & Central field good. V. 6/60 cc 3-12-36.
20	64	M	5/60 No glasses	2 weeks	Yes	None	Walker 6-5-34. Walker 7-17-34.	Recovery—Retina in place. Field full. V. 6/21, 6-25-34. Redetachment. V. 5/60, 8-1-34.
21	60	F	Illiterate Aphakic	3 mos.	Yes	Cataract oper. 4 mos. before	Walker 8-14-34	Complete failure.
22	60	M	5/60 Low myope	1 mo.	Yes	None	Walker 8-13-34	Recovery—Retina in place. Field full. V. 6/15, 4-14-36.
23	62	M	6/60	6 days	Sup. temp. V-shaped	None	Walker 9-27-34.	Failure. Large vit. hem, 1-17-35.
24	27	M	6/12+ hyp.	2 weeks	None seen	3 mos. before struck in eye by bottle cork	Walker 10-9-34.	Recovery—Retina in place. Full field. V. 6/5, 3-2-36.
25	64	M	H. M. 1 in Aphakic	10 mos.	None seen	Cat. Ext. 1 year before	Safar 10-16-34.	Failure 10-31-34.
26	61	M	C. F. below and out	3 to 4 weeks	Well ant. up and out	None	Walker 10-20-34	Unimproved. 2nd oper. advised but refused, 12-20-34.
27	28	F	6/60 No glasses	6 weeks	Several questionable tears	9 wks. before struck in eye by baby.	Walker 10-13-34. Walker 11-3-34.	Recovery—Retina in place. Field full. V. 6/45, 3-9-36.
28	32	F	1/120 high myope	7 weeks	None seen	Followed pregnancy	Walker 12-4-34. Walker 1-29-35.	Failure. V=L. P.
29	56	F	F. 3 ft. right side Emmetropic	1 mo.	Sup. temp. quad. mid. way out	None	Walker 1-28-35. Walker 2-5-35.	Failure. 1-10-36.
30	22	M	3/60 Mod. Hyp.	8 to 12 mos.	None seen	None	Walker 2-5-35	Recovery—Retina in place. Field full. V. 6/60, 5-18-35. Some macular involvement.
31	60	F	1/120 high myope	1 week	T-shaped up and out	None	Safar 12-8-34 Walker 2-12-35	Recovery—Retina in place. Field full. V. 6/15+, 3-24-36.

Case No.	Age	Sex	Vision and Approximate Refraction	Duration of Detachment	Retinal Tears	History of Injury	Type and Number of Operations	Results
32	30	M	6/30+2 low hyp.	1 week	Large tear temporal side of macula	2 mos. before puncture wound of sclera	Walker 2-19-35	Recovery—Retina in place. Field full. V. 6/6—, 3-5-36.
33	61	F	6/60 high myope	3 to 4 mos.	None seen	None	Walker 1-24-35. Walker 4-11-35	Recovery—Retina in place. Field improved. V. 6/30, 2-9-35. Unimproved—Retina completely detached. V. 1/160, 5-1-35.
34	27	M	H. M. below Aphakic	6 mos.	None seen	Mine explosion 7 yrs. before. Cat. oper. 6 mos. before	Walker 4-11-35	Failure. L. P. questionable, 3-5-36.
35	49	F	C. F. 1 m. mod. hyp.	2 weeks	None seen	None	Walker 5-23-35.	Recovery—Retina in place. Field full. V. 6/21, 4-14-36.
36	47	M	2/60 low hyp.	1 mo.	None seen	None	Safar 7-16-35.	Recovery—Retina in place. Field full. V. 6/21, 4-14-36.
37	36	M	2/60 high myope	2 mos.	None seen	None	Walker 6-27-35. Walker 9-17-35.	Improved. Retina partly reattached. Field slightly improved. V. 6/60 cc, 3-24-36.
38	61	M	6/60 Mod. hyp.	3 weeks	Inf. temp. quadrant	None	Safar 6-25-35 Walker 9-3-35. Walker 10-15-35.	Recovery—Retina in place. Field full. V. 6/21, 4-9-36.
39	21	M	6/60+1 Emmetrope	10 weeks	Several in inf. temp. quad. ant.	Blow on head 6 mos. before	Walker 9-17-35	Recovery—Retina in place. Field slightly improved. V. 6/30+1, 3-17-36.
40	59	F	6/9	1 mo.	Sup. nasal quad.	None	Walker 11-7-35.	Recovery—Retina in place. Field full. V. 6/9, 12-14-35.
41	64	F	L. P. mod. hyp.	2 weeks	None seen	None	Walker 11-16-35.	Failure. 2nd oper. advised but refused.
42	21	M	6/60 cc high myope	4 years	Inf. nasal quad.	None	Walker 11-26-35. Walker 12-3-35.	Improved. Retina in place. Full field. V. 6/60 cc., 3-10-36. mac. chord.
43	16	F	H. M. 1 M. Aphakic	1 week	None seen	Several disc. op. for cong. cat.	Walker 1-30-36. Walker 5-2-36.	Improved. Retina partially in place. Field slightly imp. V. 6/30+, 5-20-36.
44	47	M	C. F. 2 ft. High myope	3 weeks	Inf. periphery	3 weeks before	Walker 2-1-36	Failure. 2nd oper. advised but refused.

SUMMARY

Total number of cases reported	44
Female cases	14 — 31.8%
Male cases	30 — 68.2%
Cases in which myopia of varying degree was the refractive error	22 — 50. %
Cases in which two operations were necessary and done	12 — 27.2%
Cases in which three operations were necessary and done	2 — 4.5%
Cases in which retinal tears were seen	18 — 40.9%
Successful results in cases in which tears were seen	10 — 55.5%
Successful results in cases in which tears were not seen	10 — 38.4%
Cases with history of injury including five aphakic cases	13 — 29.6%
Successful results in cases following injury and aphakics	6 — 46.1%
(Five of these cases were aphakic and in only one was operation successful)	
Total cases with no improvement in field or vision and retina remaining detached	17 — 38.6%
Total of cases with slight improvement (retina partially reattached, field and central vision slightly improved)	7 — 15.9%
Total of successful results (retina in place, field full, central vision improved)	20 — 45.5%

Youngest case operated, 16 years of age. Oldest case, 79 years of age.
Average age, 45.5 years.

ROENTGENOLOGICAL CHARACTERISTICS OF DIFFERENT TYPES OF PNEUMONIA

By WILLIAM GREGORY COLE, M.D., New York, N. Y.

Read before the Radiological Section of The Medical Society of New Jersey at its Annual Meeting June 4, 1936, in Atlantic City.

The roentgenological characteristics of different types of pneumonia are of more than passing interest, and I present these different characteristics in the hope of stimulating the curiosity of roentgenologists. This is in the form of a preliminary report, and is by no means a finished product, nor are the conclusions drawn to be accepted arbitrarily. The excitation of curiosity among the roentgenologists in regards to different pneumonia types is of considerable importance. To my father, Dr. Lewis Gregory Cole, I give all credit for, so far as I know, first observing the different characteristics of different pneumonia types.

According to a probably outmoded conception, pneumonia may be roughly divided in two main types—lobar, and bronchopneumonia.

LOBAR PNEUMONIA

A lobar pneumonia is characterized roentgenologically by a homogeneous fan-shaped area of consolidation. The apex of this consolidation is usually at the hilus, and the base is at the periphery. The consolidation is usually uni-lateral, and is usually confined, at least in the early stages, to one lobe or part of a lobe. One or two margins of this fan-shaped area are clear cut and well defined, where it is in contact with a pleural reflection, either at the mediastinum, at the periphery, or at an interlobar fissure. Where a portion of the lobe is involved, that margin of consolidation not in approximation to a pleural reflection is more irregular, less well defined and indistinct.

The main differential diagnoses are an atelectasis and a pleural effusion. The shift of the mediastinum and narrowing of the intercostal spacing, and the elevation of the diaphragm on the involved side are findings which will help to differentiate an atelectasis from a pneumonic consolidation.

The more dense character of the area involved,—that is, the general uniform density of the shadow; the absence of lung margins below the upper limit of involvement; the tendency to obscure the ribs and its occurrence at the base will help to differentiate a pleural effusion from a lobar pneumonia.

BRONCHOPNEUMONIA

A bronchopneumonia is a patchy infiltration which may be roughly fan-shaped or irregularly distributed and made up of localized areas of infiltration, the size of a lobule or group of alveoli. This usually has a peribronchial distribution. The individual areas of infiltration

which constitute the integral parts of the whole lesion may be circumscribed and well defined, or very soft and indefinite; or they may vary between these two extremes.

This process is usually bilateral, but more marked on one side than on the other. It occurs more frequently in the lower lobes; but when it does occur in the upper lobes, it must be differentiated from a tuberculous lesion. If there is any confusion in the mind of the roentgenologist as to the differential diagnosis between a bronchopneumonia and tuberculosis, a single examination is usually inadequate for establishing a definite diagnosis, and totally inadequate for any typing.

TYPING

If we now divide pneumonia into four types, namely: 1, 2, 3, and 4, disregarding for the time being any attempt at the determination of the subdivisions of type 4, of which there are, I believe, 32, we have type one and type two characterized as a lobar pneumonia. The smooth fan-shaped consolidation is characteristic of type one or type two. I have not, as yet, been able to differentiate satisfactorily type one from type two, but fortunately this is of more academic than practical interest, as a polyvalent serum is effective for both types one and two.

Types three and four are bronchopneumonia, and have the characteristic patchy infiltration described above.

Type three is a sunburst type of infiltration which is bilateral, more marked on one side than the other, protruding from the hilus toward the periphery in stringy linear patches of soft mushy infiltration. It involves the central two-thirds of the lung; and in the early stages, it is not much more than a soft increase in the normal peribronchial markings. It apparently has little or no regard for pleural reflections, or interlobar fissures. It is usually accompanied by a much less evident similar process extending out from the opposite hilus. It is as insidious an appearing process as is this particular type of pneumococcus.

Type four is characterized by circumscribed patchy areas of infiltration that are relatively concrete and well defined. They have a peribronchial distribution, usually about the descending bronchi, and they are frequently bilateral, but more extensive on one side than on the other. The differentiation between type three and type four is the differentiation between virulent sunburst infiltration, and a concrete patchy circumscribed infiltration. The differentiation is as characteristic as, and similar to, the sunburst of an osteogenic sarcoma, compared to the circumscribed compact solidarity of a benign osteoma.

Of the subdivisions of group four, the only pneumonia which I found to have the characteristic appearance is that of type seven. There is more good luck than good management in this occurrence, as I am told that type seven serum is, if not the only, at least the most beneficial serum for any of these numerous subdivisions of type four.

Type seven is a miniature type three; that is, it is a sunburst type of lesion extending out from the lung root and confined to one lobe without evidence of involvement of the opposite side. It is not a stringy linear infiltration of a type three, but has more the appearance of a central consolidation, with the sunburst peripherally to the small central area of consolidation.

CONCLUSION

In conclusion, I present that the more important pneumonia types have characteristic reontgenological findings; types one and two are lobar pneumonias; type three is a stringy sunburst infiltration; type four, a more compact circumscribed patchy infiltration; and type seven, a central consolidation, with a peripheral sunburst.

If this presentation can stimulate roentgenologists to attempt a roentgenological typing of pneumonia cases by them, it will have been well conceived.

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STRABISMUS IN CHILDREN

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Read before the Pediatric Section of The Medical Society of New Jersey at its 170th Annual Meeting on June 4, 1936.

Strabismus, squint, or heterotropia, are terms given to a condition where only one eye is straight at a time. These are subdivided into three general groups as divergent, convergent, and vertical deviations; and these again may be subdivided, depending on the distance of the object of fixation, or on the direction of the gaze.

Heterophoria is a term to include all tendencies for one eye to deviate from the other, which tendency can be overcome in one way or another by a conscious or unconscious act of the child. These too may be divergent, convergent, or vertical with the same general characteristics as the tropias, except that they can be overcome.

Both heterotropias and heterophorias are again subdivided according to etiology as innervational, structural, insertional accommodative, etc.



Figure 1.—Paralysis superior rectus and inferior oblique, right eye, producing a headtilt backward.
Position of head corrected by resection of both muscles.
1. Right eye lags in looking up to the right. Superior rectus paralysis.
2. Right eye lags in looking up to the left. Inferior oblique paralysis.

CAUSES AND VARIETIES

What is the origin of the various kinds of squints? and how does one differ from another? What should you, as the child's physician, do for these cases? and when? The answers to these questions vary greatly, depending on the cause, the amount, and the cosmetic effects of deviation.

Those cases which are evident at birth are generally due to some anomaly of one or more of the ocular muscles. These may not be observed until the child is some weeks or even months old, when it begins to take more notice of things and to look about in different directions.

Such anomalies may be caused by faulty structure of the muscle where connective tissue was laid down in whole, or in part, when the muscle was forming. Examples of this type are cases of strabismus fixus and retraction syndrome. These are always congenital and often hereditary. Again a muscle may be so hypertrophied at birth, that it holds the eye in the field of its action so forcibly that the actions of the other muscles are more or less hindered.

Those due to an interference with the nerve supply are often congenital; commonly hereditary; and often acquired very early. The frequency of an innervational paralysis in cases of forceps delivery and difficult labor is striking, and one is lead to agree with the statement that the best aid to a successful delivery is a comfortable bed for the doctor.

The squints which develop after six months usually have some accommodative element. The convergent strabismus of the hyperopic child is one of this class most commonly observed. The squint may develop from six months to six years, but the great majority begin between eighteen months and the fourth year.

There is often a history of similar squints



Figure 2.—Headtilt due to paralysis of the superior rectus. Corrected at 18 months, by operation.

in the family; and heredity is an intesesting, if not an important factor.

This accommodative type is usually due to a hypermetropia, which forces the accommodation, which in turn overstimulates the act of convergence, thus causing the eyes to cross. Another theory of this type of squint is that the fusion faculty is faulty and that this causes the squint. It is not the purpose of this paper to discuss these theories which are more the problems of the ophthalmologist, but to discuss with you the problems from the side of the pediatrician.

Frequently there is a history of some illness or a fall, neither of which may be more than an exciting factor, and may really do little toward actually producing the condition. These cases on examination will show a moderately high degree of hypermetropia, the correction of which by glasses may correct or greatly reduce the amount of squint. If a full correction of the hypermetropia by glass has but little or no effect on the squint, or if the instillation of atropine in the eyes does not lessen the amount of deviation, a different or an additional etiological factor must be looked for, and additional or different treatment instituted.

The illness may have been a meningitis or poliomyelitis, or even a condition much less serious, while the fall, although slight, may have caused a slight paresis of one or more of the ocular muscles. Diphtheria is a frequent cause of sixth nerve palsies, which may be slight and may be mistaken for a convergent squint of the hyperopic type. The hypermetropia in these cases is only a coincidence, for many children with even marked hypermetropia have no squint whatever. Cases of convergent squint in children who are myopic are not uncommon, and are usually made worse by the glasses which correct their myopia, while a divergent strabismus in a near-sighted child is usually improved by wearing glasses.

Divergent squints usually develop somewhat later than convergent squints, generally from two to seven years of age; but may vary on either side of these ages. They are more common in children who are myopic or highly hyperopic.

The writer is finding more and more frequently,—probably because when one looks for trouble one usually finds it,—a convergent or divergent squint developing between the ages of two and ten. These may be slight to a moderate degree of difference in the levels of the eyes. The amount may be one-half a degree or more. When this is found with little, if any, refractive error, some one of the elevator or depressor muscles is at fault, and refraction has little if anything to do toward producing the squint. Glasses in these cases have little, if any, effect toward correcting the deviation.

A case of this kind was seen at the age of seven with a convergent squint for near, but with no squint for distant vision. There was a difference in level of three degrees. There was only a slight refractive error. No glasses were given. One year later she returned and was found to have a divergent squint for distance, but was normal for near, with binocular single vision and perfect fusion. It is the child's physician who is in close contact with the family that is in the best position to watch and direct the care of such patients.

Convergent squint is occasionally seen from purely a nervous condition.

A very marked convergent squint developed quite suddenly in a girl of fourteen years. There was only a slight refractive error, and the externi were normal. A diagnosis of chorea was made, and the squint entirely cleared under Fowler's solution. Another case was much improved by a circumcision.

An important symptom, and one which the pediatrician should be the first to detect is a faulty position of the head. The face may be rotated to the right or to the left to overcome some anomaly of the lateral rotators, while a tilting forward, backward, or toward one shoulder is strong evidence of an anomaly of one or more of the elevator or depressor muscles. The cause of a head turn or tilt should be determined as early as possible, and usually corrected at an early age if it is of ocular origin.



Figure 3.—Paresis of right and left superior recti with marked upshoot of the right and left inferior oblique, combined with a convergent strabismus.

1. Right eye fixing, left eye turns in and up.
2. Left eye fixing, right eye turns in and up.
3. In looking up to the right, the right eye lags and the left shoots up.
4. In looking up to the left, the left eye lags and the right eye shoots up.

5-6. Eyes down and right and down and left.

7. Result after tenotomy of right and left inferior obliques.
8. After resection of left external rectus.
Final result, binocular single vision with depth perception.

TREATMENT

Treatment can be taken up only in general in the time allowed; but with the many causes for squints, the treatment must be varied. Hence, a correct diagnosis made as early as possible is most important. The pediatrician and the ophthalmologist must then work in unison.

Glasses give marked improvement in some cases; but when the improvement is not immediate, or is not seen within three or four months, little may be expected from this form of treatment.

A treatment at present much in vogue, is most important to consider. Muscle training, fusion exercises, and orthoptic exercises, and the like are, in many cases, of decided benefit. In many cases they take the rôle of a good thing carried too far. For technicians and the like to give orthoptic training, except under strict supervision of an ophthalmologist, is wrong. Furthermore, for an ophthalmologist to continue orthoptic training without consulting with the pediatrician or family doctor is also wrong. If the acquiring of fusion were the ultimate height of success, it would be dif-

ferent; but the ultimate aim should be to produce a fit member for society. Orthoptic training is often continued so long a time that the patient is made a neurotic.

If satisfactory results from fusion training are not obtained in a few weeks, or if constant recourse has to be made to orthoptic exercises to keep these results, such training should be discontinued for the good of the child's general well being.

The writer is strongly in favor of such training in carefully selected cases if not continued too long, but to add all of our squints to the 100,000 guinea pigs, and to give them all prolonged orthoptic training, is dangerous practice; and the pediatrician or family doctor is the one who should check such training when the patient's nervous system has had all it should stand.

OPERATIVE TREATMENT

Operative treatment again varies with the type of case with which one is dealing. One variety may safely be operated as early as eighteen to twenty months, while others should be treated by other means first, depending on the type of squint. One should try to have a good cosmetic effect, however, by the time the child is of school age.

One can hardly appreciate how early a child becomes sensitive about the deformity of a squint. A child operated some months ago is now four and one-half years old. When told recently that he was soon to have a baby brother, he said, "Mother, I hope he isn't cross-eyed." Another boy, age four years, six months, refused to look at the test objects, hung his head, and muttered something which his mother interpreted as a request for my nurse to leave the room. After she left, the tests were continued without any trouble. The mother said he was so sensitive, that he would let no one but her see him without his glasses which correct his squint so that it is much less noticeable. The early complex developed in children having squints is the most important symptom. This may be caused by the squint itself, or by the treatment with glasses, orthoptic training, constant patching of one eye, or any of the various methods of treatment. When such a complex develops, the eyes should be made cosmetically straight and other methods of treatment discontinued as much as is possible.

A squinting child with an amblyopic eye, or one without fusion, may never miss these things, because he either never had them, or had lost them early. Nevertheless, they are happy children, unless they have so disfiguring a squint that it causes them to be the butt of ridicule of their playmates.

A correction of the deformity, by surgery if necessary, is the greatest aid one can give these patients; if the other results can be gotten without too great a cost in nervous energy, time away from play, etc., the result is more ideal from the standpoint of the ophthalmologist; possibly not from the standpoint of the child or the pediatrician.

15 Park Avenue, New York City

THERAPEUTIC AGENTS NEW AND OLD—ARTICLE NO. 1

SULFANILAMIDE

Under this heading, the Joint Committee on Professional Relations of The Medical Society of New Jersey and the New Jersey Pharmaceutical Association will present, from time to time, pertinent information on therapeutic agents. These articles will supersede, for the present, the "Seasonable Prescription" series which has appeared bi-monthly in the Journal.

This month's topic is of particular interest and importance because of the widespread publicity given to sulfanilamide in lay and medical publications.

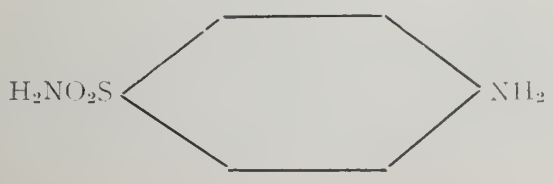
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SULFANILAMIDE IN THE TREATMENT OF STREPTOCOCCIC INFECTIONS

Laboratory and clinical studies carried out in this country and abroad have shown that p-aminobenzene-sulfonamide is effective against streptococci, in vivo as well as in vitro. Recently the Council on Pharmacy and Chemistry of the American Medical Association adopted the name sulfanilamide to designate the above compound. Sulfanilamide is indicated in conditions in which the beta haemolytic streptococcus may be expected to play a prominent rôle. These conditions include puerperal fever, septicemia, erysipelas, influenza, nasal, post nasal and throat involvement of haemolytic streptococcal origin, such as septic sore throat, otitis media, and mastoiditis. Early in 1935, Domagk, in Germany, announced a startling chemo-therapeutic success in that mice which were injected with haemolytic streptococci of human origin survived when an azo dye containing the sulfonamide group was injected. In France, Lebaditi and Vaisman reported similar results with an azo compound synthesized by Girard. At present there are a number of therapeutic agents capable of preventing the multiplication of streptococci in the body, but they are all basically related to one compound, namely, sulfanilamide, the formula of which is shown below:



Trefouel and his collaborators found that the complicated chemical structure as found in prontosil and related azo compounds, is not essential for therapeutic efficiency and that the parent sulfonamide, a colorless compound, was equally effective or superior to azo sulfonamides.

These compounds are so new that as yet their mode of action is obscure. However, this fact is known, the multiplication of streptococci in the peritoneal cavity in mice is prevented within a few hours following administration. Experiments carried out to determine the therapeutic efficiency of the parent substance and related compounds not only show that sulfanilamide has the higher therapeutic activity but evidence is available to show that other compounds, such as prontosil, are undoubtedly converted to the parent compound in the body and that this conversion is necessary for therapeutic activity.

Colebrook and Kenny have reported a series of sixty-four cases of puerperal fever treated with compounds containing the benzene sulfonamide group. In the entire group there were only four deaths, indicative of a greatly decreased death rate with treatment as compared to the average for the preceding four years when other methods of treatment were employed. Long and Bliss have in this country reported nineteen cases of various haemolytic streptococcic conditions treated with sulfanilamide and related compounds with only two deaths. In their hands, sulfanilamide given

over long periods of time was not toxic in doses as high as one gram per twenty pounds of body weight per day.

Discombe recently called attention to sulfhemoglobinemia caused by the coadministration of saline laxatives, such as magnesium sulphate with sulfanilamide. Although this condition is not serious unless the total haemoglobin falls below 30 per cent (by the Haldane schedule) and readily disappears by discontinuing the administration of the drug, it should be avoided and care taken to withhold the administration of magnesium or sodium sulphate.

Marshall, Cutting and Emerson, in a recent paper, studied the excretion of sulfanilamide and found that it may be recovered almost quantitatively from a twenty-four-hour urine. Even after oral administration, a large part of the sulfanilamide may be recovered from the urine.

Whether the action of the benzene sulfonamide compounds is confined purely to haemolytic streptococci, is yet to be discovered. Preliminary experiments indicate that it may prove useful in the fields of pneumococcus and meningococcus infections. The powerful action of sulfanilamide is shown by the fact that one part in 12,000 in one cc. of human blood is capable of destroying the majority of 15,000 streptococci in six hours and completely destroy them in twenty-four hours.

Dosage: Oral dosage of sulfanilamide may be calculated on the basis of one gram (fifteen grains) for each twenty pounds of body weight, up to 100 pounds. Five grams represents the maximum daily dose in adults that may be used with safety. This and smaller doses is divided into four doses given six hours apart. Long and Bliss state that as much as three to five grams per day may be given for a period of weeks without untoward effects. However, some patients have complained of tinnitus, nausea and dizziness. Since sulfanilamide is a relatively new therapeutic agent, its use should be attended with caution and extreme optimism avoided.

Caution: Avoid coadministration of saline laxatives, which may produce sulfhemoglobinemia, or other toxic manifestations. Too large or prolonged dosage may cause undesirable reactions.

SULFANILAMIDE MUST BE USED WITH CARE

A CASE REPORT

By H. A. Tarbell, M.D., Newark, N. J.

The phenomenal success which has followed the oral administration of sulfanilamide, especially in the treatment of gonorrhoea, has placed a pharmaceutical in the hands of the medical profession which can be compared to arsphenamine in the treatment of syphilis.

The rapid disappearance of the infection after a few days' treatment with the drug is nothing short of miraculous. Physicians who have had many years of experience in the treatment of genito-urinary diseases are amazed at the rapidity with which it operates and have not been slow in taking advantage of it when called upon to treat gonorrhoea.

When sulfanilamide was first introduced, new users of the drug were especially cautioned as to overdosage, and to prohibit the exhibition of magnesium or sodium sulphates while taking the sulfanilamide, as the patient is very liable to be overwhelmed by sulphur, and the symptom complex sulfhaemoglobinemia, with its accompanying dangerous complications may result. This is a disaster, almost a catastrophe, for it opens the way for some patients to start legal proceedings against his doctor; it may hurt the physician's reputation, and there is the danger of death to the patient in complicated cases.

Sulfanilamide may be administered safely for a few days (three to five) to patients suffering from acute gonorrhoea, in dosage of ten grains every six hours, when amelioration of symptoms will generally occur. Subsequently five grains three times daily for four or five days may be given. Available information records the fact that further administration of the drug is unnecessary.

The patient should be advised that he is taking a powerful drug, and that he *must* follow the physician's directions explicitly. He should be told that he is liable to be made very ill if he does not do so.

Having had just such a case in my practice, I appealed to the Secretary of the State Board of Pharmacy of New Jersey with a hope that some regulation in reference to sulfanilamide be made, to discourage its indiscriminate sale over the counter by druggists, and thereby

prevent further accidents. I was advised by Dr. Fischelis that the Board had already taken measures for its regulation.

To amplify the above remarks, a report of a case of sulfhaemoglobinemia follows:

The patient, a young man, aged twenty-two, white, unmarried, perfectly healthy in appearance, presented himself at my office for treatment of a urethral discharge of two days' duration. Smears taken and immediately examined microscopically showed enormous numbers of gonococci.

The action of the new drug sulfanilamide was described to the patient, with the alternative of the old method of treatment which requires months to effect a cure. The patient decided to take the sulfanilamide. In writing, careful directions as to its dosage were given, and he was especially cautioned *not* to take salts while taking the sulfanilamide. Three days afterwards the patient reappeared, smiling. He declared he was *well*, and examination failed to show evidence of urethral discharge. His urine was a trifle cloudy, but contained no shreds. He was instructed to reduce the tablets (five grains) to three in twenty-four hours for four or five days more, and he was not seen again until seven days elapsed, when I received an urgent call to see him at his home. I found him in bed and very sick. His temperature was 104.2, pulse 120, resp. 30, trembling, cyanosed, coughing a great deal, had fifteen bowel movements, and could not retain food without vomiting.

As he had started his illness with a chill while at work, and examination of his chest showed evidence of congestion, he was sent by ambulance to St. Barnabas' Hospital, Newark. He gave a history of disregarding the physician's directions, and had taken ten grains of sulfanilamide every six hours regularly for ten days altogether. He had also taken a dose of Epsom salts.

I am grateful to the interne, Dr. Chernus, for the following data regarding the patient after he reached the hospital and for his work upon the case:

Temperature 104.4, pulse 130, resp. 30.

Chest Examination—Capillary bronchitis of both lungs.

Abdomen—Distended

Genito-Urin.—No evidence of urethral discharge, no redness of glans.

Urinalysis—Albumin present. Spec. grav. 1025, hyaline and granular casts. No blood seen.

Blood Analysis—Haemoglobin 83 per cent, erythrocytes 4,400,000, white cells 8000 with 56 per cent polys.

Sputum—Negative for types I, II, and III.

Chest X-Ray—Negative.

Treatment—Rest in bed, forcing of fluids, sulfanilamide discontinued, vaso dilatation by alcohol.

Subsequent History—Temperature fell to normal in three days. Cyanosis disappeared, albumin disappeared, and lungs cleared up. Nausea and vomiting and diarrhoea checked, and he was discharged from hospital at end of one week. Although still weak at the end of seven days from release from the hospital, he went back to work, and is now quite well again.

Remarks—It is quite evident that sulfanilamide, *uncontrolled*, is a dangerous drug, and is irritating to the lungs, heart and kidneys.

BOARD OF CHEMISTRY ACTION

Based on the foregoing clinical report, as well as reports from other sources, the Board of Pharmacy of the State of New Jersey, on June 8th, passed the following resolution:

"*Whereas*, Considerable publicity has been given in lay publications to the effectiveness of sulfanilamide in a variety of infectious diseases, thereby leading to possible employment for self-medication, and

"*Whereas*, The use of this drug is contraindicated under some conditions and is attended with certain dangers unless employed in accordance with specific directions of physicians to suit particular cases, be it

"*Resolved*, That the Board of Pharmacy issue a warning to the public and to pharmacists that the promiscuous and unsupervised sale and use of sulfanilamide is contrary to the public interest; and that pharmacists be requested to dispense this drug only on the prescription of physicians."

This resolution will be circulated to the pharmacists of the State of New Jersey, and will also be given national publicity, as it is quite clear that public interest demands that a proper check be placed upon the indiscriminate use of a valuable drug, such as sulfanilamide, so as to prevent serious injury. It would be a calamity if a drug of this character became the basis of patent or proprietary medicines, used for self-medication. The medical profession alone can prevent this by prescribing the drug, and refusing to permit patients to ask for it by name. Nothing leads to self-medication more rapidly than the elimination of the prescription in supplying therapeutic agents.

THE TREATMENT OF THREATENED AND HABITUAL ABORTION

MATERNAL WELFARE ARTICLE NUMBER EIGHTEEN

By David B. Gershenfeld, M.D., Newark, N. J.
Attending Obstetrician, Newark Beth Israel Hospital

Read before the New Jersey State Society of Surgeons, at the Newark Beth Israel Hospital, January 6, 1937

Next to the life of the mother, the greatest concern of the obstetrician is the life of the baby. We all know how great is the disappointment of the doctor if he should be called upon, at the termination of a delivery, to tell the mother that her baby is not alive; and the concern of obtaining a live baby is not centered solely upon a successful delivery. This concern begins long before the woman goes into labor. It begins soon after she becomes pregnant, and continues throughout her pregnancy. For the disappointment is almost as great if the mother loses her baby, through abortion, early in pregnancy. This brings us to the subject of threatened and habitual abortion.

It is not my purpose here to go into all the causes and various treatments of threatened and habitual abortion, but rather to go briefly into a method of treatment, which, though by no means new or original with us, we have found very satisfactory.

Before we knew much about the internal secretions of the ovary and its correlated glands, our treatment of threatened abortion was to put the patient to bed, either with the foot elevated or flat, give her some sedatives, and then wait for further developments. If the patient aborted, we would not take the blame, since we felt that we had done all we possibly could. If the patient did not abort, we took the credit. However, I do not believe we were entitled to the credit, since we did nothing outside of putting the patient completely at rest,—which, however I admit is an important part of the treatment. I do not believe that the administration of morphine in these cases was a great help in the prevention of abortion, since Falls, Lackner, and Krohn have shown that morphine, grain one-quarter, did not decrease the contractions of the puerperal uterus after the injection of one c.c. of pituitrin; but on the contrary actually increased them.

PROGESTERONE TREATMENT

With the advance in our knowledge of the hormonal secretions of the pituitary, the follicle, and the corpus luteum, and their effects upon the uterus, our rationale in the treatment of threatened abortion improved greatly.

In 1903 Fraenkel showed that the corpus luteum was necessary for the continuance of pregnancy in its early stages. Allen and Corner proved that progestin or progesterone, which is secreted by the corpus luteum, was necessary for the conservation of early pregnancy.

Knaus and Manzi showed that progesterone keeps the uterus in a quiescent state during pregnancy; and that when the influence of progesterone is removed, the uterus becomes more sensitive to the action of pituitrin.

Falls, Lackner, and Krohn in their work on the "Effect of Progestin and Oestrin on Human Uterine Contractions" have shown that progesterone abolished the contractions of the puerperal uterus which were induced by the introduction of a hydrostatic bag. They also showed that if contractions were induced by the injection of pituitrin, these contractions were inhibited by an injection of progesterone. If progesterone were first injected to desensitize the uterus, pituitrin did not elicit any contractions. Smith and Smith have shown that progesterone promotes the elimination of oestrin from the blood into the urine.

From these facts it appears that normal pregnancy is maintained as follows: The corpus luteum secretes progesterone, which decreases the amount of oestrin in the blood, and thus desensitizes the uterus to its natural contractile response to pituitrin. Labor then ensues when, due to the degeneration of the corpus luteum, the amount of progesterone

present in the blood is very much diminished or becomes nil, thus allowing an increase in the amount of oestrin in the blood and so causing the uterus to respond to the action of pituitrin.

Premature labor or abortion, then, follows along the same line whenever, for any reason, the corpus luteum does not function properly and the amount of progesterone becomes insufficient.

Progesterone, however, was not available commercially until a few years ago, and so we tried to induce a greater stimulation of the corpus luteum to a greater formation of progesterone by injection of the luteinizing factor of the anterior pituitary in the form of antuitrin S. Witherspoon, in 1931, had shown this to be feasible. We treated sixteen women with antuitrin S. Twelve of these were carried to term successfully or gave birth to living babies; four aborted. This gives a successful outcome in 75 per cent of the cases treated.

About two years ago we were able to obtain some progesterone in the form of proluton,—one-fifth of a rabbit unit,—manufactured by the Schering Corporation. Later when progesterone became more plentiful because of its manufacture synthetically from the soy bean, we have used it in doses of one international unit.

METHOD OF USE

Our procedure is as follows: In cases which give a history of one or more spontaneous abortions without any discoverable etiology, we give an injection of one unit of progesterone weekly. During the week of the expected menstrual period two or three injections are given. These injections are given intragluteally. Should the patient complain of regular uterine pains, the interval is decreased to twice a week or oftener. If the patient is bleeding, either in a case of habitual abortion or in a primagravida, one unit is injected daily, or twice daily, until the bleeding and contractions cease or are greatly improved; and then the interval is lengthened to one a week. We believe that there is no danger of an overdose doing harm. Giving more than is needed is wasting it, and most of our patients cannot afford this, since the drug is rather expensive.

The patient, of course, must be kept in bed during the time she is bleeding or has severe uterine contractions. It is important not to let the patient out of bed too soon. We do not use morphine. This method of treatment we have found very satisfactory. We treated twenty-seven women with progesterone, and of these, twenty went to term or had a living baby; seven aborted. This gives a successful termination in 74 per cent of the cases treated.

One of our patients had aborted five times. As soon as she missed her menstrual period, in her sixth pregnancy, she was given one unit of progesterone weekly up to the ninth month, and at term she gave birth to an eight-pound baby. Another patient, one of those reported as a failure, received one unit weekly, but aborted about the third month. This was her second abortion, having received no treatment during her first. When she again became pregnant, she was again given injections of one unit weekly with an occasional extra dose when she complained of uterin contractions. She gave birth to a live baby.

In conclusion, I want to say that treatment of threatened and habitual abortion with progesterone is rational and scientific, and is a step forward. It will most probably prove more effective when we know more about the dosage and when we will have a test for progesterone in the blood.

SCIENTIFIC EXHIBITS

THE SCIENTIFIC EXHIBITS OF THE 1937 ANNUAL MEETING

ARTICLE NUMBER ONE

By ASHER YAGUDA, M.D., Newark, N. J., Chairman

In spite of the theoretical handicaps imposed by the holding of the annual meeting of the American Medical Association at Atlantic City in June, the meeting and exhibits of the State Medical Society were this year bigger and better than ever. The Scientific Exhibits were composed of fifty-two individual booths, demonstrating a wide variety of the recent advances in medicine by the three great avenues of approach to the mind,—the picture, the specimen, and the personal demonstration.

The physical arrangement of the meeting was such that all of the visitors to the scientific sessions came in contact with the various exhibits, with the result that many of the doctors found much of interest and of educational value, regardless of their particular speciality. This year the committee attempted to arrange groups of exhibits showing various phases of the same subject,—a sort of symposium. This type of grouping was adopted in the fields of endocrinology, peripheral vascular disease, traumatic diseases, and syphilis.



View of Exhibit Room seen from Above

FRESH PATHOLOGY EXHIBIT

Because of the tremendous appeal of the fresh pathology exhibit at the 1936 session, it was decided to continue the fresh pathology exhibit as a permanent feature of the future annual meetings. Again, during this session, great interest was displayed in the demonstration of fresh autopsy material which was obtained daily throughout the session from Dr. Richard Custer, Pathologist of the Philadelphia General Hospital.



Fresh Pathology Exhibit

MOTION PICTURES

The moving-picture theatre proved its worth this year, and developed a great deal of interest. Scientific motion pictures,—some in color, and some with sound,—were shown twice daily. During most of the time the theatre had standing room only.

AWARDS

At this year's session, awards for original exhibits, and for the best compilation of material were given. The awards for scientific exhibits of original research were bestowed upon the following exhibitors:

First Award—Drs. William Exton, and Anton R. Rose, of Newark, New Jersey, for an exhibit on Erythrocytometry by means of the Electroscopometer.

Second Award—Drs. William Bierman, and E. A. Horowitz, of New York City, for an exhibit on the Treatment of Gonorrhea in Women by means of a Combined Heating Tecnic.

Third Award—Drs. Joseph B. Wolffe, and V. A. Digilio, of Temple University, Philadelphia, Pennsylvania, for an exhibit on the Etiology of Angina Pectoris and its Treatment by Enzyme-free Pancreatic Tissue Extract.

The awards for the best compilation of material and excellence of presentation were bestowed upon:

First Award—Dr. J. W. Cutler, Henry Phipps Institute, University of Pennsylvania, Philadelphia, Pennsylvania, on Pleural Adhesions Complicating Pneumo-thorax Therapy.

Second Award—Dr. I. Seth Hirsch, School of Medicine of New York University, on the Roentgenkymographic Examination of the Heart, a method of graphically recording the cardiac movement by the x-ray.

Third Award—Dr. C. R. Rein, of New York City, on Kline Tests for the Detection of Syphilis.

The Committee on Awards, under the chairmanship of Dr. Robert A. Kilduffe, had a very difficult time in deciding these awards as there were many other exhibits worthy of consideration. This committee has recommended that at the next annual session three awards also be given for local exhibitors, so as to encourage the preparation of better exhibits by our own men.

In order that a large number of the members of the State Medical Society who did not have the opportunity of being present at the Atlantic City session might reap some of the benefits and learn some of the lessons of the Scientific Exhibits, the Committee on Scientific Exhibits, through the coöperation of Dr. Overton, the Editor of the Journal, and with the sanction of the Board of Trustees of the State Medical Society, has arranged for the publication in the State Medical Journal of some of the more instructive exhibits. In this and succeeding issues of the Journal will be published photographs of exhibits, together with a brief statement by the exhibitor of the purpose of the exhibit and of the lessons which may be deduced from them. The Committee on Scientific Exhibits urges the members of The Medical Society of New Jersey to read these summaries, as they will help to keep them abreast of the most recent advances in medicine.



The Motion Picture Theatre

ENDOMETRIAL BIOPSIES

STUDIES OF NORMAL AND ABNORMAL PHASES OF MENSTRUATION

By Daniel R. Mishell, M.D., Newark, N. J.

An exhibit consisting of photomicrographs of material obtained by suction biopsy was arranged to demonstrate the histological and pathological changes occurring in the endometrium. This study was based on material selected from a series of three hundred endometrial biopsies. To facilitate a better understanding of the exhibited sections, a brief description of the various phases of the normal menstrual cycle is in order.

PROLIFERATIVE PHASE

The first or proliferative phase starts immediately after the cessation of menstruation and continues until the time of ovulation, usually from the fourth or fifth day, up to the twelfth or fifteenth day of the cycle. At this time the endometrium is characterized by proliferation of the cells which comprise the endometrial glands, it being under the influence of estrone, the hormone produced by the Graafian follicle.

SECRETORY PHASE

Immediately after ovulation, under the combined influence of the estrone and progesterone, the hormone arising from the corpus luteum, a change in the character of the glands takes place which can be shown by endometrial study within thirty-six hours after the rupture of the follicle. This is the beginning of the second or secretory phase which persists until the time of menstruation. The duration of this stage is fourteen days and, as we shall attempt to show, can be subdivided into several sub-phases: 1, that occurring just after ovulation; 2, that at the height of secretion; and 3, that immediately prior to the onset of menstruation.

MENSTRUAL PHASE

The third stage of the cycle is that of menstruation itself, which is usually about four days in duration and is believed to be influenced by withdrawal of hormonal stimulation.

THE MICROSCOPIC SECTIONS OF NORMAL PATIENTS

The first section (Fig. 1) is that of an endometrial specimen taken five days after the onset of the period. There is little activity, as evidenced by the small, round, tubular glands composed of low columnar cuboidal cells whose nuclei appear at the base, the stroma being fairly compact.

Five days later (Fig. 2), under the influence of estrone, the glands are larger, the cells being high columnar, with piling up and crowding of their nuclei, called *pseudo-stratification*. Mitotic figures are seen close to the lumen of the glands, this being the site of the most active growth of cellular structure.

One week later (Fig. 3) there are beginning convolutions of the glands, with a clear zone appearing between the basement membrane and the nuclei. This is the first indication of secretion, and is due to a subnuclear accumulation of glycogen, called the "glycogen ring". This is a definite action of progesterone, and is evidence that ovulation has already taken place.

Five to seven days later (Fig. 4) the picture has again changed. The glands are definitely convoluted and have grown much larger; the progesterone effect is at its height; the nuclei of the glands have been pushed down to the base of the cells by the glycogen secretion, and these nuclei appear to have assumed a regular formation, well described as "regimentation". The cells are of the high columnar type, and retain their outline. The stroma cells have grown larger to resemble decidual cells. This is also an effect of progesterone.

Three or four days later (Fig 5), just prior to menstruation, the glands begin to show signs of disintegration. The lumenar margins of the cells become frayed, and their outline broken. The nuclei become pyknotic, and many capillaries make their appearance in the stroma where there is beginning infiltration of red blood cells, polymorphonuclears, and lymphocytes. At this point it is believed hormonal influence is no longer felt upon the endometrium, and menstruation is about to take place. The last phase in a normal cycle is menstruation itself (Fig. 6), which shows broken-down glands, amorphous tissue, and red blood cells.

MICROSCOPIC SECTIONS FROM ABNORMAL PATIENTS

Among the abnormal cases studied by means of endometrial biopsies, the first group are those of amenorrhea due to menopause. An example of this condition (Fig. 7) is one seen in artificial menopause produced by x-ray castration, for functional bleeding in a twenty-

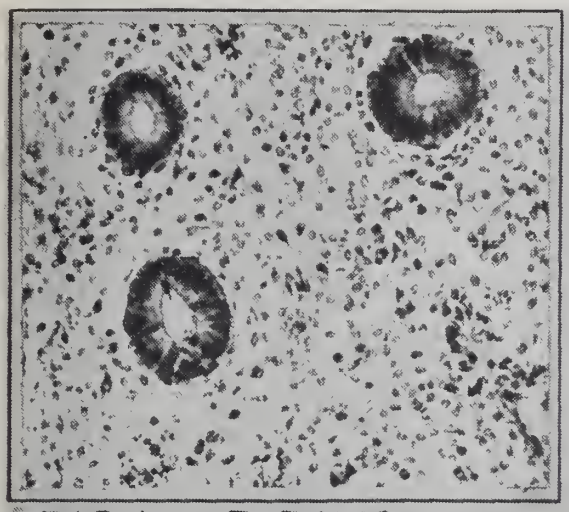


FIG. 1 5 DAYS

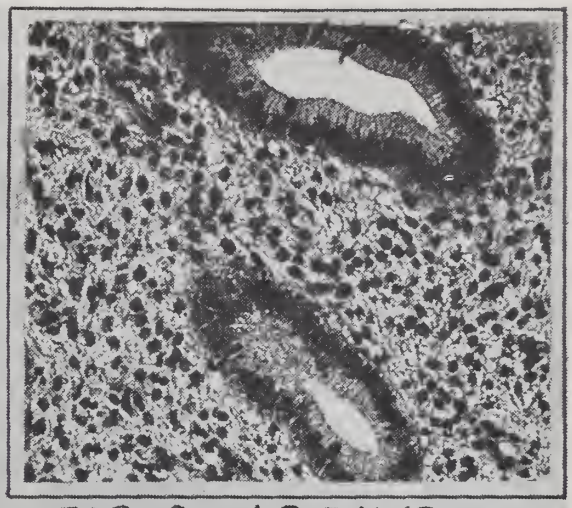


FIG. 2 10 DAYS



FIG. 3 17 DAYS

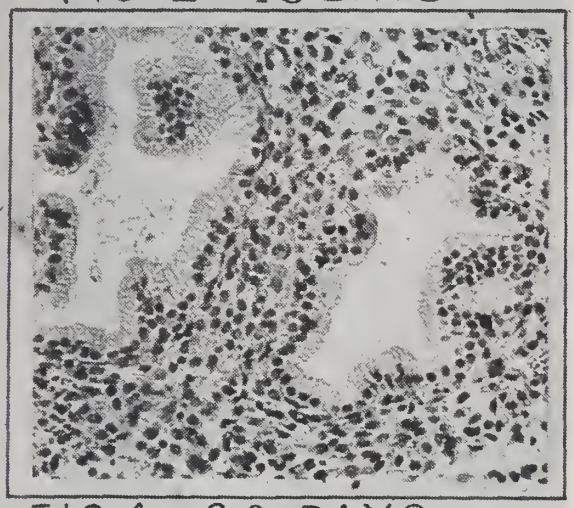


FIG. 4 22 DAYS

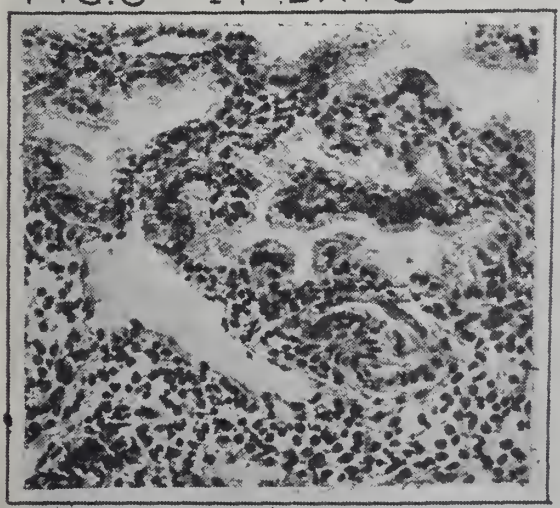


FIG. 5. 25 DAYS

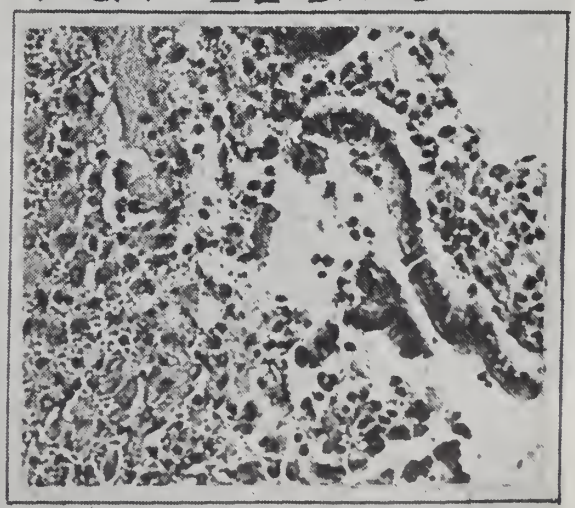


FIG. 6. MENSTRUATION

Changes in the Endometrium During a Normal Menstrual Cycle.

eight-year-old patient. The glands are small and appear to be quite atrophied; the cells are cuboidal with nuclei at the base. There is no evidence of any hormonal activity whatsoever. This is the result of the destructive action of the x-ray upon the ovaries and upon the endometrium itself.

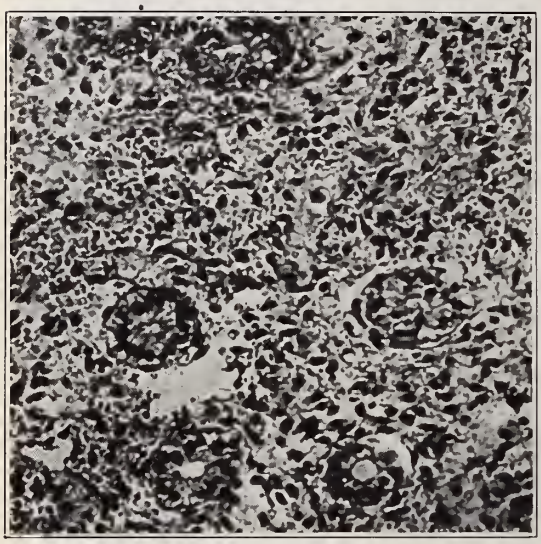


Fig. 7—Amenorrhoea after x-ray.

Clinically, the patient suffered from severe hot flashes following the onset of the menopause, the symptoms being controlled by the administration of large doses of estrogenic hormone.

The next case (Fig. 8) is that of natural menopause in a woman fifty-two years of age, in which the glands are small and irregular, with an over-abundance of stroma tissue.

Among the ovarian dysfunctions with failure of completion of the normal cycle, the endometrial biopsy often reveals the presence of cystic changes in the glands. This is shown in a case of secondary amenorrhea with sterility (Fig. 9), the periods occurring every four to six months. Following therapy with estrogenic hormone, definite proliferation (Fig. 10) was obtained, and bleeding took place after the hormonal stimulation was stopped. From the biopsy we know that this period was anovulatory with no corpus luteum effect, and was probably due to the sudden withdrawal of estrone.

Another appearance of cystic changes was observed in a case of dysmenorrhea in a girl of twenty-two, having a hypoplastic uterus with the cycle prolonged to six weeks in dura-

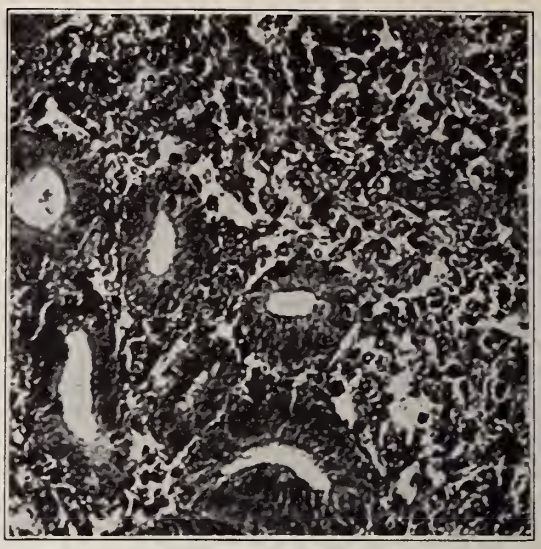


Fig. 8—Natural menopause.



Fig. 9—Cystic glands wi h sterility

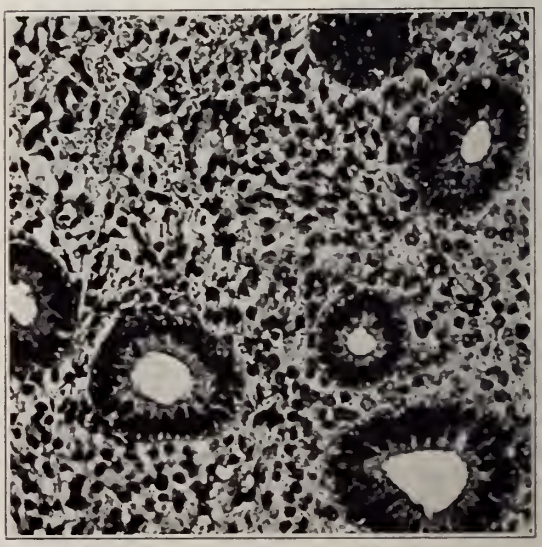


Fig. 10—Effect of hormonic treatment.

tion (Fig. 11). Following therapy with estrogenic hormone during the first two weeks, and progesterone the latter half of the cycle,



Fig. 11—Dysmenorrhoea and six-week cycle.

a biopsy study revealed glands, regular in size and shape, showing good evidence of secretion (Fig. 12). Clinically the patient menstruated shortly afterward and was entirely free from pain.

Endometrial studies may also reveal the presence of subacute or chronic inflammation. An example of this is seen in a sterility case in which all other examinations were essentially negative and the endometrial picture showed definite evidence of large groups of

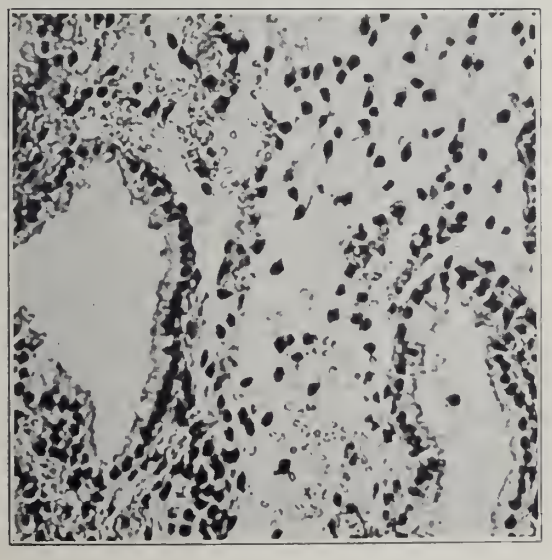


Fig. 12—Effect of hormone treatment on Fig. 10.

polymorphonuclear leukocytes completely filling the lumen of the glands (Fig 13).

Another example of infection is seen in a case of a patient suffering from menorrhagia and metrorrhagia in which the glandular struc-



Fig. 13—Exudate in the glands.

tures were almost entirely replaced by inflammatory cells, and the stroma was the site for large collections of polymorphonuclear leucocytes and round cells (Fig 14). Following appropriate therapy by pelvic heating with diathermy, the picture changed to that of a

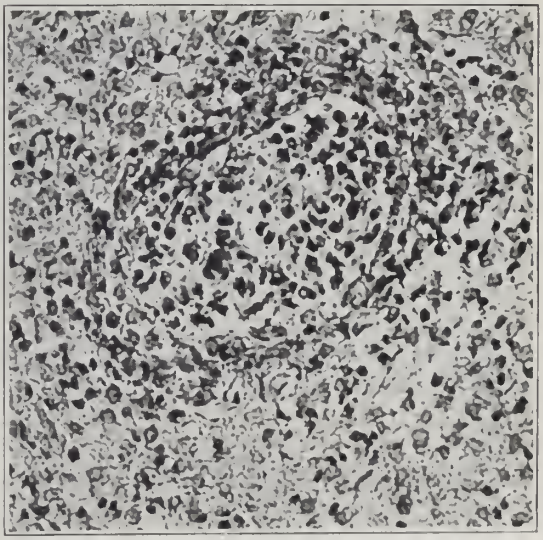


Fig. 14—Gland filled with exudate.

normal endometrium (Fig. 15), and the periods became regular. This teaches us that non-endocrine factors should not be overlooked in cases of irregular bleeding.

Finally, a case is shown with a history of

functional bleeding for three years. Following a period of metrorrhagia lasting three weeks, accompanied by many clots, a biopsy revealed an endometrium which indicated early pregnancy (Fig. 16). This is shown by the large

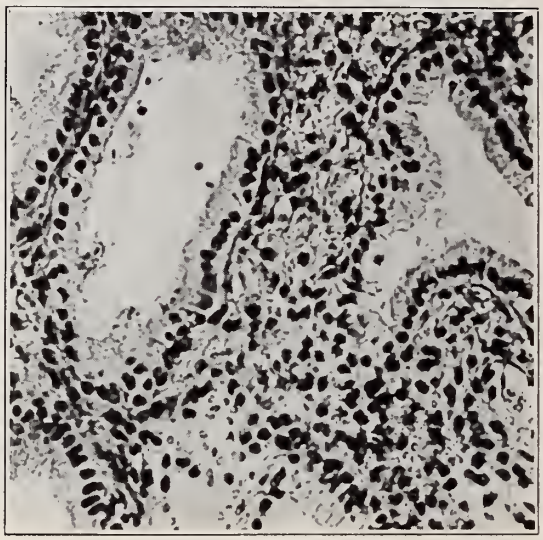


Fig. 15—Clearing of gland after treatment.

decidual cells of the stroma, and the high degree of secretion of the glands, indicating the presence of a corpus luteum of pregnancy. The pregnancy was not disturbed by the biopsy. Ordinarily, in view of the profuse bleeding, the patient might well have been subjected to a regular dilatation and curettage under general anesthesia, under which circumstances the pregnancy would certainly have been interrupted. An Ascheim-Zondek test corroborated the biopsy findings, and in view of the history of prolonged bleeding the patient was treated with large doses of progesterone. The bleeding promptly stopped and the patient is well advanced in her pregnancy at the present time.

SUMMARY

1. The normal menstrual cycle has been demonstrated with reference to the physiological effects of the ovarian hormones.

2. Amenorrhea, due to menopause, has been shown with reference to clinical symptoms and changes following therapy.

3. Ovarian dysfunction with evidence of incompletion of the normal cycle and cystic changes have been shown in cases of secondary amenorrhea and dysmenorrhea.

4. Infections of the endometrium in cases of sterility and irregular bleeding have been demonstrated.

5. An early pregnancy associated with functional bleeding has been shown and the clinical course and treatment indicated.

Conclusions.—We believe that the study by means of endometrial biopsies has enhanced our knowledge and understanding of both the normal menstrual cycle and certain abnormal phases, whether of organic or of endocrine



Fig. 16—Endometrial gland in early pregnancy.

origin. The procedure has proven both simple and safe in a series of over three hundred cases; and we believe it is a valuable addition to the diagnostic equipment of the modern gynecologist.

PREPITUITARY—FEMALE AND MALE SEX HORMONE ASSAYS, AND CLINICAL SIGNIFICANCE

By Drs. Robert T. Frank, M. A. Goldberger, U. J. Salmon, Gertrude Felshin, and E. Klempner

From the Department of Laboratories, The Mount Sinai Hospital, New York City.

The exhibit consists of charts, graphs, and photographs which illustrate mainly the clinical methods and the quantitative estimation of estrogenic and gonadotropic hormone substances circulating in the blood and excreted in the urine.



Sex Hormone Assays

The charts show the stimulating effect exerted by the pituitary on all the endocrine glands; and also the special effects produced on the gonads of both sexes, and through their intermediary, upon the end organs which are the external and internal sexual apparatus of the male and female. They likewise show such chemical formulae of the sex hormones as are at present known, and emphasize the chemical similarity of both the male and female sex hormones.

The technics employed give quantitative results and are clinically of use in determining the gravity of conditions, in trying to locate their source of origin, and as a help in determining the methods of treatment. They are fully as quantitative as most clinical methods, as for example, the basal metabolism test.

The material for the assays consist of blood specimens—usually 40 or 50 cc.—taken every week; and the entire urine output over a month, usually assayed in three-day specimens.

A technic has been developed by means of which the same blood specimen can be utilized for both estrogenic and prepituitary determination. This is based on the fact that the estrogenic factors are lipoid soluble, the prepituitary factor lipoid insoluble. After the extracts have been concentrated, the estrogenic are tested by the vaginal spread method (Allen and Doisy) on castrated mice; the gonadotropic by the effect exerted on the ovaries of immature rats (Philip Smith; Zondek). The technics for the former have been described by Frank and Goldberger, and the latter by Frank and Salmon. These blood specimens, taken only once a week, give only a partial insight into the circulatory hormonal conditions.

The assays of the urine which are continued over a full month, give the full amounts of estrogenic and gonadotropic substances excreted by a given patient. The assays are based on technics developed in our laboratory.

The graphs shown are based on several hundred normal patients, obtained over a period of ten years. The normal, fertile, menstruating woman has an extremely characteristic graph, both as far as circulatory and excretory conditions are concerned. A large number of graphs illustrating hormonal conditions with hypo-, as well as hyper-functional disturbances, demonstrated the hormonal differences encountered in these disturbances.

In the main, hypo-functional conditions include the groups clinically known as oligomenorrhea, amenorrhea, dysmenorrhea and functional sterilities, as well as the menopause (artificial and spontaneous).

The hyper-functional conditions include most cases of menorrhagia and metrorrhagia of purely functional origin as well as "premenstrual tension" unassociated with excessive bleeding.

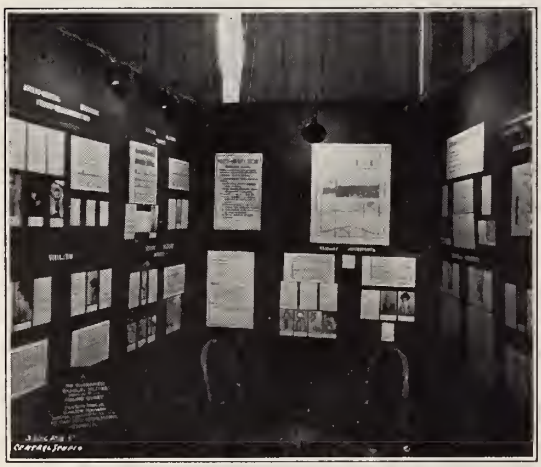
The exhibit likewise contained many photographs of patients, graphs, x-rays, etc., covering the representative endocrine diseases including the thyroid, pituitary, parathyroid, adrenal, pancreatic disturbances, both under- and overfunctional.

In addition there was a miscellaneous group illustrating particular diagnostic problems and therapeutic effects, both induced and accidental.

DIVERSIFIED CLINICAL AND PATHOLOGICAL PICTURES OF FAILING OVARIAN FUNCTION

By Rita S. Finkler, M.D., and Milton Friedman, M.D.
From the Laboratories of the Newark Beth Israel Hospital, Newark, N. J.

The clinical manifestations of ovarian failure vary widely. The syndrome of ovarian failure is encountered in patients presenting amenorrhea of either primary ovarian or pituitary origin, or secondary amenorrhea. Functional uterine bleeding of puberty and maturity are also manifestations of ovarian failure. Inhibition of ovarian function, together with partial or total amenorrhea and oligomenorrhea, is found in virilism and pseudo-hermaphroditism. This inhibition is believed to be a result of overactivity of the androgenic zone of the adrenal cortex. Ovarian failure, whether occurring during the reproductive period, or at menopause, may be followed by compensatory pituitary hyperplasia. This may produce migraine headaches, and vaso-motor disturbances. The clinical cases herein exhibited present various phases of these dysfunctions.



Failing Ovarian Function

The schematic chart represents the normal relationship between the anterior pituitary, the ovary, the endometrium, and the breast, as well as the cyclic curves for the estrin and prolan excretions as determined biologically.

Two cases of primary amenorrhea are presented. The one on the left is due to primary ovarian failure, and the one on the right is due to primary pituitary failure. Both cases were treated by means of ovarian and pituitary hormones. Intensive administration of estrogenic hormone (progynon B—50,000 international units) resulted in several cyclical uterine bleedings, as well as breast and endometrial growth. With the cessation of treatment, there was endometrial regression accompanied by amenorrhea.

On the right we find three cases of secondary amenorrhea. The first, presenting fibrotic and cystic ovaries, was treated by partial resection of the ovaries. The second case, observed over a period of five years, failed to respond to endocrine therapy. Stimulation x-ray therapy was followed by irregular menstruation. The third case responded after alternating the administration of ovarian hormones in their physiological sequence (progynon B, followed by proluton).

Above the cases of secondary amenorrhea are shown three cases of pituitary hyperplasia, following ovarian failure. The center case had severe migraine headaches, with vertigo and blurred vision. The daily bio-assays over a period of one month revealed excessively high prolan excretion. Administration of amniotin and progynon B temporarily relieved the symptoms for a few days after each injection. For a more prolonged result, a large dose of x-ray therapy was administered to the pituitary gland with marked improvement. Two menopause cases are featured exhibiting ovarian failure with high prolan excretion and atrophy of the endometrium. Oral medication of emmenin capsules (concentrated) in one case, and intramuscular injections of progynon B in the other case, resulted in the disappearance of vaso-motor symptoms, lowering of the prolan excretion, and growth of the endometrium. Frequent vaginal smears (Papanicoloau and Schorr method) revealed an estrogenic phase during and following therapy.

To the left of the schematic chart are shown two cases of functional uterine bleeding. The first had been bleeding profusely since puberty (one and a half years before treatment). Each of four injections of two cc. of antuitrin S was followed by a moderate diminution of the flow for a few days. Small-dose stimulating x-ray therapy to the ovaries resulted in establishment of normal menstrual periods. This patient has been observed over a period of seven years. Lately there has been a tendency to short periods of amenorrhea lasting two to four months.

The second patient, with pituitary obesity,

complained of sterility and moderate but continuous bleeding for two months, following a period of amenorrhea. Four consecutive weekly bio-assays of the urine revealed an absence of prolan excretion, and a low estrin excretion. Four weekly endometrial biopsies, taken simultaneously, revealed a proliferative phase, but no secretory phase. Intramuscular injections of pituitary and pituitary-like substances did not stop the bleeding. Small dose x-ray therapy to the pituitary and ovarian regions resulted in the establishment of normal menstrual periods. An endometrial biopsy taken one day prior to the fourth period revealed secretory activity characteristic of the luteal phase, and the presence of a twelve-day-old embryo, to be described by Dr. Carl G. Hartman and Dr. George Streeter of the Carnegie Institute of Embryological Research, Baltimore, Md. After five additional normal monthly periods, the patient again became pregnant. She is now receiving bi-weekly injections of proluton to aid the maintenance of this pregnancy.

On the extreme right are shown two cases of virilism, and one case of pseudo-hermaphroditism. The case of pseudo-hermaphroditism with amenorrhea presents a picture of masculine body configuration, absence of breast development, hypertrichosis of face and body, a small vaginal introitus, and an enlarged clitoris measuring two and one-quarter inches long, and resembling a penis. Laparotomy revealed normal female pelvic organs and adrenal gland contours. The enlarge clitoris was amputated. The patient was then treated with hormone therapy and pelvic diathermy. She had eleven menstrual periods, which occurred only when estrin was administered. Radiation therapy was then given to the region of the adrenal glands, and this was followed by five periods. She has not menstruated for eight months.

The second case had secondary amenorrhea, extensive hypertrichosis of the extremities, and a marked beard on the face and chin. The external genitalia appeared normal. A laparotomy revealed normal uterus and tubes. Both ovaries were moderately cystic. The left adrenal, on palpation, seemed enlarged. A left adrenalectomy was performed four months later by Dr. L. R. Broster, of London, England, and Dr. Charles Robbins, of Newark, N. J. Some of the excessive hair has been falling out, and normal menses have been reëstablished.

All the above-mentioned cases are fully illustrated by the following: photographs, detailed charts correlating bleeding, therapy, and endocrine bio-assays. In most instances microphotographs of the endometrial and ovarian biopsies, and vaginal smears were presented.

OBITUARY

DR. A. CLARK HUNT

Dr. A. Clark Hunt died in his home in Metuchen on July 11th, 1937, as the result of an accident. He was born on March 17th, 1859, in Metuchen. He graduated from Princeton, and received his medical degree from the College of Physicians and Surgeons.

Dr. Hunt practiced in Metuchen; and in 1886 joined the staff of the State Board of Health. He served as Assistant Secretary of the Board for many years; and as Chief of the Bureau of Medical and Sanitary Inspection until the Board of Health was reorganized in 1915.

He was Chief of Bureau of Medical Supervision from 1915 to 1923.

He was Editor of Public Health News 1919-1923, and retired to Metuchen on February 1, 1923.

Dr. Hunt was a genial man, and was well liked and respected by his associates.

The death of Dr. A. Clark Hunt recalls the distinguished services of his father, Dr. Ezra Mundy Hunt, who was rightly called "The Father of Public Health in New Jersey". A two-page obituary of him appears in the Transactions of The Medical Society of New Jersey of 1895, page 206. The salient points of his life are as follows:

Dr. Ezra Mundy Hunt was born in Metuchen January 7, 1830. He graduated from Princeton in 1849, and from the College of Physicians and Surgeons in 1852. He served in the Civil War as Surgeon of the 29th New Jersey Infantry. He was President of The Medical Society of New Jersey in 1864.

In 1866 Dr. E. M. Hunt started agitation for better sanitation in New Jersey, and was made President of the State Sanitary Commission. Largely through his efforts, the need of a State health organization was recognized, resulting in creating the State Board of Health in 1877. Dr. Hunt was appointed its first Secretary, and remained the leader of the Department until his death on July 1, 1894.

STATE SOCIETY ACTIVITIES

PROGRAM FOR 1937-1938

By William G. Herrman, M.D., President, Asbury Park, N. J.

A program in any year of The Medical Society of New Jersey should, so far as possible, embrace the three-fold objectives for which the Society exists, namely:

1. To protect and further the rights and privileges, within the field of the practice of medicine, of those whom the State has recognized by license as competent to practice the healing art;

2. To recognize and seek to carry on the responsibilities and duties that go hand in hand with these rights and privileges;

3. To carry on education and instruction in matters pertaining to health among our own members, the profession outside the society, and the general public.

Our committees are roughly divided into two classifications—those known as the *Standing Committees,* and those which are *Sub-Committees* of, or *Advisory Committees* to, the large general *Welfare Committee.*

Our Standing Committees deal largely with our own organization's work, and yet they too play a part in the three objectives listed above. The committees that deal with the *Annual Meeting,* with *Post-Graduate Education,* and with *Publication* help to fulfill within and without the Society our desire to increase knowledge in all health subjects. Our committee for liaison with the *Woman's Auxiliary* is intimately interested with the instruction of the general public of our aims and objectives.

STANDING COMMITTEE ON THE ANNUAL MEETING

Chairman, Dr. Charles B. Kaighn

This year you will note that there has been a re-grouping of the committees assigned to conduct the Annual Meeting. There is now one General Committee responsible for the entire program of the meeting. This general committee has two *Sub-Committees* that deal with the program, and the exhibits, the chairmen of which are members of the general committee. At this season of the year it is too early for them to report on their program of next June, but we can rest assured that the committees assigned will not allow the 1938 meeting to suffer by comparison with previous meetings.

STANDING COMMITTEE ON POST-GRADUATE EDUCATION

Chairman, Dr. Harry H. Satchwell

This committee, in conjunction with the Committee on Preventive Procedures of the New Jersey Branch of the American Academy of Pediatrics, will give at no cost a series of five lectures on *Preventive Procedures* in reference to the *Pre-School Child* at various centers in the State. Teachers from various universities will be employed, and the cost will be borne by the State Department of Health.

Other courses will be arranged by the Post-Graduate Committee after its October meeting, following which representatives of the committee will meet with the Post-Graduate Committee of each County Society. The County Societies will as heretofore be allowed their choice of subjects and lecturers. These courses will be "the regular courses".

STANDING COMMITTEE ON MEDICAL DEFENSE AND INSURANCE

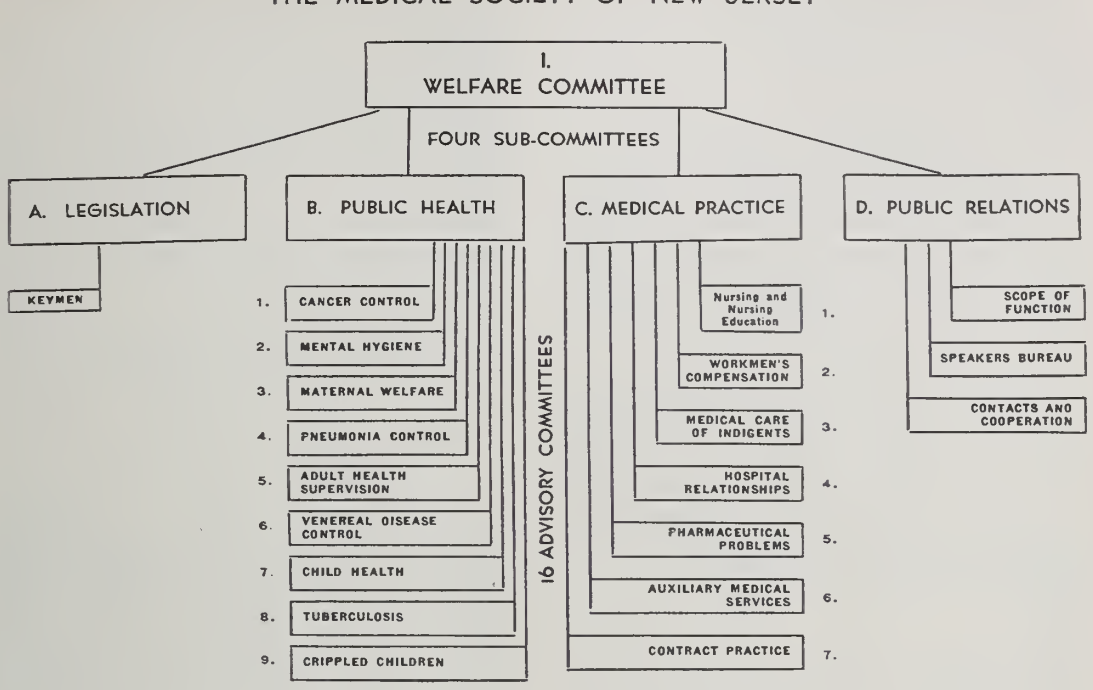
Chairman, Dr. Christopher C. Beling

This year the subjects of *Medical Defense* and *Insurance* have been given to one committee. This committee will at a later date publish its proposals based on the action of the House of Delegates and the Board of Trustees at their last meeting. They are working on a plan to add hospitalization insurance to the Medical Society's group policy, which will make it very much more desirable.

THE WELFARE COMMITTEE

Chairman, Dr. Hilton S. Read

The Welfare Committee may be considered as our *general executive committee,* with four sub-committees. The two Sub-Committees on Public Health and Medical Practice have such advisory committees as seem necessary to cope with the various phases of their problems.



The Relations of the Welfare Committee to its Sub-Committees and their Advisory Committees.

Dr. Hilton S. Read has phrased the general duties of the committee as follows:

1. Serve as a clearing house of information:

a. From the component societies to the State Society (as an aid in deciding on policy).

b. From the State Society to the County Societies (to secure coöperation, and assure a united front when policy is set).

2. Serve as a cohesive agent:

a. In welding opinion within the Society;

b. In arousing our members to activity;

c. In securing public support for our philosophy.

3. Serve as an aggressive leadership group:

a. In the personal interest of the practicing physician;

b. In the unselfish interest of the sick;

c. In the unselfish cause of preventive medicine.

SUB-COMMITTEES TO THE WELFARE COMMITTEE

In the beginning of this article, I mentioned the grouping of the activities of the committees under three headings. The activities of the Sub-Committees to the general Welfare Committee will fall readily into this grouping.

The *Sub-Committees on Legislation* and *Medical Practice* have to do largely with the rights and privileges of the profession. They are ever on guard against legislation and other activities which are subversive to the best interests of the profession. The Legislative Committee, in addition, is on watch to oppose bills that are not in the best interest of the health of the community, and to further those pieces of proposed legislation which will be of service to the general welfare.

The *Medical Practice Committee,* in addition to its watchfulness over the best interests of the profession, has advisory committees, such as those on *Nursing and Nursing Education, Workmen's Compensation,* and *Medical Care of the Indigent,* which are working in the interest of those for whom we feel responsibilities.

The *Public Health Committee,* and its nine *Advisory Committees,* are concerned almost entirely with the duties and responsibilities of organized medicine to improve public health, and to act as expert advisers to all those organizations—lay, governmental, and medical—which are interested in various phases of preventing and curing disease.

Our *Committee on Public Relations* is part of our educational program. We wish to place before the public in general and before organized groups of the laity, such as the Parent-Teachers Associations, Welfare Organizations, and others, accurate and concise information

in all lines dealing with medical practice and public health, and to impress upon the public our philosophy in regard to the relationship of the medical profession and the public at large.

SUB-COMMITTEE ON LEGISLATION

Chairman, Dr. William H. Areson

1. The *Legislative Committee* proposes this coming year, through the Executive Officer, to ascertain the attitude of each legislator toward all bills of interest to our profession, and to explain the position taken by our profession on these bills.

2. Each County Society will, as last year, form *Legislative Committees* and select *keymen*. The legislators appreciate the interest shown by active keymen in each county.

3. When advisable, this committee will be prepared to secure the introduction of bills in which the profession is interested.

Dr. Areson very timely makes the following remarks:

"We should all realize that every member of our Society must become politically-minded if we are to make progress. We must apply ourselves to the business of governing ourselves; and in order to accomplish this, every member should be willing to accept his responsibilities as a member of our Society."

SUB-COMMITTEE ON PUBLIC HEALTH

Chairman, Dr. Stanley Nichols

The Sub-Committee on Public Health has nine Advisory Committees.

ADVISORY COMMITTEE ON CANCER CONTROL

Chairman, Dr. Henry B. Orton

The Advisory Committee on *Cancer Control* believes:

1. There is a definite need and a great opportunity in this State for the development of proper facilities for the diagnosis and care of those suffering from various forms of cancer. Through the use of institutions already established, such as State and county hospitals and a few voluntary hospitals, facilities could be established shortly for the custodial care of those beyond medical aid and without proper facilities at home for nursing care.

2. That the State must be surveyed, and groups established according to population and geographical location for the proper diagnosis of cancer and tumors, so that those sufferers may be given proper medical care early in the course of their disease. It is equally important that either these groups be able themselves to offer the proper care, or that they have connections so that the cases diagnosed by them can be referred for adequate care. It would be inadvisable to establish diagnostic groups where such treatment is not available.

3. That each County Society should appoint a Cancer Control Committee to study the subject in its own locality, and be able to report to the State Committee the need and the possibilities for the establishment of both diagnostic and therapeutic groups. Care should be taken that such groups, in caring for the indigent or low-wage patient, do not compete with private agencies already doing good work, but rather that they will coöperate with them and refer proper cases to private agencies.

ADVISORY COMMITTEE ON MENTAL HYGIENE

Chairman, Dr. James S. Plant

The Advisory Committee on *Mental Hygiene* hopes to interest the general practitioner in the work being done in the *Mental Hygiene Clinics* in the *State Hospitals*. Your President, however, is also interested in seeing that, through this committee, the men in general practice become more interested, and perhaps more familiar with cases developing neuroses who are pre-institutional and who can be very definitely helped by wise counsel and sympathy and perhaps a little medicine, and probably be kept from developing psychoses. This subject could be well presented by interesting speakers before County Societies; and the general profession can be interested in this manner in attending clinics conducted by the State Institutions. When we consider the large number of hospital beds in this country devoted to the care of mental cases, it is easily apparent that the medical profession at large has a great duty in trying to prevent as many cases as possible from becoming institutionalized either through the use of mental clinics or in the privacy of the consultation room.

ADVISORY COMMITTEE ON MATERNAL WELFARE

Chairman, Dr. Arthur W. Bingham

The Advisory Committee on *Maternal Welfare*, coöperating with the *State Department of Health*, will seek to provide:

1. A field physician in every county.
2. Adequate provision for prenatal care.
3. Adequate provision for hospitalization in well-equipped obstetrical hospital units.
4. Hospitals open to general practitioners to attend their own obstetrical cases, subject to supervision by an obstetrical staff, and with rules for consultation in abnormal conditions.
5. Regular conferences of maternal wel-

fare groups to be held with all physicians interested in obstretrics, for the discussion of causes of complications, how to prevent them, and how to treat them; as well as reasons for maternal deaths. This year the committee will, upon request, send an obstetrician of experience to lead the discussion at any of these conferences.

6. Investigation of every maternal death, not for criticism, but to check the diagnosis and cause of death, and to help prevent another.

7. Free nursing delivery service for the low-wage group of patients.

8. Free consultation for the low-wage group.

9. Free consultation for midwives in the same way.

10. Refresher courses given for the physicians who wish to observe some of the more modern methods in obstetrics.

11. A maternal welfare article printed each month in The Journal of The Medical Society of New Jersey, as in previous years.

12. Statistical studies to continue, with the making of charts and graphs showing how the different counties stand regarding various causes of maternal deaths.

The committee urges.

1. More care in the handling of normal cases.

2. More and earlier consultations in abnormal cases.

OUR GOAL

"Adequate supervision and care for every expectant mother in New Jersey."

ADVISORY COMMITTEE ON PNEUMONIA CONTROL

Chairman, Dr. John W. Gray

The bill which was introduced into the Legislature for the appropriation of $25,000 to buy serum for those unable to pay for it, did not pass.

The program for the Advisory Committee on *Pneumonia Control* for the time being is limited to the collection of data on the facilities for typing of cases in the various parts of the State. Mr. MacDonald, of the State Department of Health, is now collecting this data for the committee. In addition, the committee will study other forms of the treatment of pneumonia besides that with serum, some of which were on exhibit at the A. M. A. Convention in Atlantic City in June.

ADVISORY COMMITTEE ON ADULT HEALTH SUPERVISION

Chairman, Dr. Edwin G. Dewis

The Advisory Committee on *Adult Health Supervision* is a new committee formed this year for the study of *periodic health examinations*. Since this committee is only recently organized, no program can as yet be published until the members have had an opportunity to study the subject as it relates to our State.

ADVISORY COMMITTEE ON VENEREAL DISEASE CONTROL

Chairman, Dr. C. Byron Blaisdell

The Advisory Committee on *Venereal Disease Control* will present an educational program by:

1. Providing literature regarding the treatment of the disease.

2. Making available to those physicians who are interested, courses, demonstrations, and visits to approved clinics;

3. Organizing *County Venereal Disease Control Committees* in order to carry out the educational program for the members;

4. Setting up a list of qualifications for clinic physicians.

ADVISORY COMMITTEE ON CHILD HEALTH

Chairman, Dr. Stanley Nichols

This committee during the coming year intends:

1. To develop speakers on *Child Health* for county and State groups. Dr. Walter B. Stewart is Vice-Chairman of the committee for this purpose.

2. To prepare forms for the physical examination and a continuous follow-up of each individual from conception to the end of development. There will be five of these forms, covering:

a. Pre-natal period.
b. Infancy.
c. Pre-school period.
d. School age.
e. Adolescence.

3. To continue the campaign against diphtheria and smallpox in the Public Health Hour, with free toxoid and free vaccination.

4. To provide health supervision by the family physician from the beginning of life to the end of school life.

ADVISORY COMMITTEE ON TUBERCULOSIS

Chairman, Dr. B. S. Pollak

The Advisory Committee on *Tuberculosis* hopes during the year to make more of the

membership of the Society tuberculosis-minded in order that more cases of incipient tuberculosis may be discovered, and fewer of the advance cases and more of the early cases will reach the sanatoria in time for their proper care. It should be kept in mind that, while more operative procedures are being used in sanatoria, in many instances, for the arresting of the progress of the disease, nevertheless many of these cases become semi-invalids for the rest of their lives. If such cases could be diagnosed early and receive proper medical care, such operative procedures would not be necessary. To accomplish this purpose the committee hopes to stimulate the use of Mantoux and similar tests, together with x-ray examination for the discovery of incipient cases through private, semi-private, or public agencies.

ADVISORY COMMITTEE ON CRIPPLED CHILDREN

Chairman, Dr. Barclay W. Moffat

The Advisory Committee on *Crippled Children* hopes this year to re-check, so far as possible, all crippled children in the State through the doctors who have cared for them in the past, in order that there may be a survey of the needs in regard to hospitalization costs, and the expense of equipment such as braces.

The committee also plans to make a further study of the qualifications of orthopedic surgeons and the hospitals doing work for the commission. The question of remuneration of the doctor taking care of these cases has been left untouched for the present, with the thought that it can be worked out in accordance with whatever proposal the Welfare Committee arrives at in regard to the care of the indigent and low-wage groups.

SUB-COMMITTEE ON MEDICAL PRACTICE

Chairman, Dr. Thomas K. Lewis

Under the *Sub-Committee on Medical Practice,* there are seven *Advisory Committees.*

ADVISORY COMMITTEE ON NURSING AND NURSING EDUCATION

Chairman, Dr. A. Charles Zehnder

The Advisory Committee on *Nursing and Nursing Education* will, so far as possible, try to put into effect the program arranged last year, which received such hearty endorsement from the House of Delegates.

1. That the didactic teaching of the nurse should, so far as possible, be given to the pupil nurse before her bedside instruction is commenced. The committee feels that it might take some time to even attempt this experimentally, but it believes that it can at least bring the subject to the attention of the training school authorities as often as possible, and perhaps in the future they may be able to try this method of teaching.

2. The committee is interested in the training of *Nursing Attendants.* This will be started in the Essex County Vocational School this Fall. The committee believes this should be its main objective this year. It is the more urgent one and can be established the more easily.

ADVISORY COMMITTEE ON WORKMEN'S COMPENSATION

Chairman, Dr. J. Irving Fort

The Advisory Committee on *Workmen's Compensation* expects to ask the Governor to appoint a commission by selecting from each interested group two representatives, together with one member from the Assembly and one from the Senate. This commission would then study and discuss the present compensation law with changes such as were proposed by the committee last year and adopted by our House of Delegates. (Annual Report of Officers and Committees, 1937, page 275, April Journal.)

ADVISORY COMMITTEE ON MEDICAL CARE OF THE INDIGENT

Chairman, Dr. Charles H. Schlichter

The Advisory Committee on *Medical Care of the Indigent* hopes to reach an agreement with the *Finance Assistance Commission,* so that indigents requiring medical care outside of institutions will receive care in much the same manner as they did while the Emergency Relief Administration was functioning, so that each patient will have free choice of physicians and the doctor will be compensated by the State, county, or municipality. Dr. Schlichter reports that the *State Finance Assistance Commission* views this arrangement favorably, and he hopes within a short time to have a working arrangement in force.

ADVISORY COMMITTEE ON HOSPITAL RELATIONSHIPS

Chairman, Dr. Raymond J. Mullin

The correlation of facts obtained from the questionnaire sent out last year by the *Advisory Committee on Hospital Relationships* has proven to be a bigger piece of work than was contemplated. Based upon the facts so revealed, which are still being studied, the committee has the following objectives in mind:

1. Proper representation of the medical profession on hospital boards.
2. Integration of out-patient and house staff activities and relationships.
3. Correction of abuses:
a. Flat rate cases (tonsil, maternity);
b. Pay clinics;
c. Treatment of compensation cases by hospital clinics;
d. Financial investigation through the Medical-Dental Service Bureau, with better medical social service.
4. Consideration of facts developed by New Jersey and New York Hospital Surveys.
5. Consideration of above and allied problems as they apply to State, county, municipal, general, and private hospitals.

ADVISORY COMMITTEE ON PHARMACEUTICAL PROBLEMS

Chairman, Dr. Chester I. Ulmer

The Advisory Committee on *Pharmaceutical Problems* plans to:

1. Start a new feature in the August Journal. It will be a series of bi-monthly articles covering recent developments in the use of therapeutic agents and new drugs. For the time being, at least, this will replace the prescriptions which have been appearing in the Journal.

2. Maintain and improve friendly relationships between the physician and the pharmacist. One means of obtaining this, the committee feels, would be to have joint meetings between physicians and pharmacists; and the committee could have speakers available at any time on subjects of mutual interest.

ADVISORY COMMITTEE ON AUXILIARY MEDICAL SERVICES

Chairman, Dr. William W. Maver

The Advisory Committee on *Auxiliary Medical Services* is a new committee which has been organized to study the relationship between the laboratory, x-ray, and physio-therapy technicians, and the medical profession. The committee hopes to be of service to these subsidiary workers, and also to correct such abuses as may be present where lay workers trained in their various fields may be practicing medicine rather than acting as technical assistants.

The committee will also study the subject of *nurse anesthetists* in this State, for here, probably more than in the other fields mentioned, there has been the practice of medicine by lay assistants. Since this committe has just been organized, it has not had an opportunity to delve as yet very deeply into its subject matter and can speak only in very general terms at the present time.

ADVISORY COMMITTEE ON CONTRACT PRACTICE

Chairman, Dr. Reuben L. Sharp

The Advisory Committee on *Contract Practice* is preparing a questionnaire to be sent to all licensed practitioners of medicine in the State of New Jersey concerning the subject of contract practice as it is now in force in industrial jobs, schools, and compensation work on contract. Until this information is obtained, the committee is not in a position to recommend the correction of any specific abuses. The Medical Society of New Jersey should have some very definite statements relative to all types of contract practice for the guidance of its members.

SUB-COMMITTEE ON PUBLIC RELATIONS

Chairman, Dr. Joseph H. Kler

The Sub-Committee on *Public Relations* has a most ample program for the coming year. To briefly summarize this program, the committe plans:

1. To have a *State Speakers' Bureau;* and a Speakers' Bureau in each county.

2. To arrange, through the Woman's Auxiliary, to have meetings with the laity, and to supply speakers from the State or County Medical Society at such meetings. The committee is preparing folders containing an outline of an address, or an address itself, together with a prepared news release of the address. These addresses can be used by the speakers as models or as prepared. Addresses are contemplated before the Parent-Teachers Associations, Women's Clubs, and Men's Service Clubs.

3. The preparation of a package library on various health topics, and on medical economics. These packages will be available to lay organizations as well as medical societies.

4. Newspaper publicity with articles properly prepared by a journalist, so as to influence the laity to view medical problems from our viewpoint.

5. A program for radio broadcasts.

6. To contact, in coöperation with the Executive Officer and Legislative Committee, the State and Federal legislators. The committee hopes to do this in such a way as to maintain friendly relationships, and to send messages pertinent and quite brief that will represent both sides in controversial matters.

7. *A State-wide Health Day.* Dr. Kler's personal contribution to the program is a promulgation of a State-wide Health Day. He

has set an excellent example of this in Middlesex County by originating a "Health Week" in New Brunswick (Jour., May, 1936, p. 311); and there have been many requests from different groups for material such as he has used in New Brunswick.

The committee urges all other committees to avail themselves of the publicity department of the State Society.

CO-OPERATION

Your President, in presenting the above program for the coming year, has not sought to express his own ideas as to what the Society should do, but to present as briefly as possible the program of each committee as the committee itself, through its Chairman, views its work for the coming year. To this end he wrote to each Committee Chairman and asked for an outline of the work of his committee for the coming year. There was a most gratifying response in spite of the time of the year and the weather.

I trust that the membership at large will read this tentative program, and if they have any suggestions to make that they will write directly to the Chairman of any committee in whose province their suggestions may properly fall. I have every wish for a bigger and better year that will keep the Executive Offices in Trenton humming.

REPORT OF THE NEW JERSEY DELEGATES TO THE A. M. A. MEETING

Atlantic City, 1937

By Walt P. Conaway, M.D., Chairman of Delegation

If the ever-increasing attendance at the meetings of the American Medical Association proves anything at all, it must mean that the medical profession, in general, is becoming definitely more interested in the problems of organized medicine.

The meeting of the American Medical Association in Atlantic City on June 7-14, 1937, was by far the largest gathering of medical men at any one time in the history of the world. At the meeting in Atlantic City in 1935, there were 8469 Fellows present; of this number there were 303 Canadians. At the 1937 meeting, there were 9764 Fellows present. Of the 175 members of the House of Delegates, there were 168 present. The Secretary reported that the present number of Fellows of the Association is more than 106,000.

In addition to the regular meetings of the House of Delegates, a special meeting was held in order to hear an authorized message from President Roosevelt, delivered by U. S. Senator J. Hamilton Lewis.

SPECIAL PROBLEMS

Among the many problems which were considered by the House of Delegates were:

Resolutions proposing amendments to the By-Laws to create a Committee on Distinguished Service Medals and prescribe its duties; as well as to create a Distinguished Service Medal.

The committee to study contraceptive practices and related problems reported in favor of placing the responsibility of the examination of products used in contraception on various medical councils. It recommended that doctors in general become more familiar with the legal rights pertaining to this matter and it suggested that all such practice be in charge of licensed physicians in regular clinics.

A special committee was appointed to study the problems of *Motor Vehicle Accidents*, and another committee to report on Medico-Legal Blood Grouping Tests.

One of the most important subjects brought up under new business concerned the development of a *National Health Program*. A special committee was appointed to formulate a national health policy for submission to the government, and further be empowered to confer with government agencies, and also with any other medical groups, so that differences in conception, definition of terms, and applicability of principles and procedures may be ironed out in conference regarding those matters in the above principles and proposals which are of national scope and to the end that they may be enacted.

RESOLUTIONS

Among the other resolutions which were introduced under New Business may be mentioned:

A resolution requiring physicians on staffs of accredited hospitals to be members of the A. M. A.

A resolution recommending the establishment of a Council on Medical Ethics and Economics.

A resolution requesting a change of name of the Section on Obstetrics, Gynecology and Abdominal Surgery, by omitting the words "Abdominal Surgery".

A resolution providing for a review and censorship on all medical motion picture films.

A resolution providing for the production of educational films to be shown to the laity.

A resolution from The Medical Society of New Jersey calling for an investigation of the conduct of the magazine Hygeia, particularly as to articles that prescribe for the laity; and another resolution from the same State regarding continued opposition of the Copeland Food and Drug Bill. (For action taken, see Jour. Med. Soc. N. J., July, p. 468.)

A resolution concerning some proposed amendments to the Constitution, especially making provisions for a succession in office in case of death or disability of the President-Elect.

A resolution on the establishment of Public Relations Committee.

A resolution condemning the practice in some hospitals of the employment of nurses, technicians and lay individuals as anesthetists.

A resolution was unanimously adopted recommending to the House of Delegates that a *Council on Industrial Health* be established.

A representative of the American Bar Association, Colonel W. W. Evans, was invited to address the House. He made a very concise, instructive, and illuminating talk concerning the problems which are of joint interest to the medical and legal professions.

Mr. R. Watson Jones, Official Representative of the British Medical Association, was introduced to the House. He made a few very cordial remarks in the nature of greeting, and an expression of good will and good fellowship to the American Medical Association.

Some slight changes were recommended in the proportioning of members of the House from the different States. These changes will result in a slight reduction in the total number of Delegates, from 175 to 174.

Several Special Committees—the Committee to Study Air Conditioning, the Committee on Asphyxia and the Committee on Scientific and Therapeutic Research—made additional reports which were referred to the proper reference committees.

The Trustees recommended that invitations for meeting places of the Association be solicited three years in advance.

ADDRESS OF PRESIDENT-ELECT J. H. J. UPHAM

In his presidential address, Dr. Upham stated he had attended sessions of component State and County Medical Societies in seventeen States, from Vermont to Utah, and from Wisconsin to North Carolina. He further stated:

"Some of the conditions which affect medical practice are the diversity of climatic conditions from Maine to California and from the Dakotas to Florida. Largely because of these, together with topographic accessibility to foreign countries, there have been definite trends in immigration, causing different racial mixtures in various sections. To realize this in general terms, it is only necessary to mention the large element from Middle and Southern European countries settled in our metropolitan cities of the East, the influx from Northern Europe and especially the Scandinavian Countries to the Northwest, the immigrant from the Orient and Mexico in the West and Southwest, and the large Negro element in the South. From these topographic and racial conditions alone one may see the insurmountable obstacles to providing a standardized practitioner or a single standardized type of medical practice."

Dr. Upham further stated, that while traveling over the country he was greatly impressed by the feeling of unrest in medical circles, manifested in the frequent discussions of the socialization of medical practice, the resentment against the charges of the prevailing inadequacy of medical practice, and medical responsibility for alleged excessive cost of medical care.

In his judgment the number of medical society meetings has become burdensome; and a study of the programs shows a lack of systematic planning.

Dr. Upham would recommend to the Council on Medical Education in Hospitals that its next logical step should be to survey the present conditions, particularly to study the possibilities of the traveling post-graduate courses now in existence in several States, with the hope of bringing modern medical developments to practitioners living in the more isolated areas. He would especially draw the attention of all component societies to the almost overwhelming mass of misinformation and false statements constantly issuing through the radio, through the daily press, and through some so-called popular magazines, directly inspired by anti-medical sources. A conference of representatives of component state societies to consider this subject seriously, would in the judgment of President Upham, be of considerable value in checking this propaganda.

ADDRESS OF PRESIDENT HEYD

President Dr. Charles Gordon Heyd, in his farewell address, said:

"The personal and environmental conditions of life are improving everywhere in the United States; and that on account of the many new discoveries, medicine is to be rated well in advance of any of the physical sciences. It is apparent that medical care is a problem not alient to the purpose of the government for the health of its citizens must be one of the paramount considerations of the State.

"Four factors contribute to the medico-social disabilities of the present day: 1, The utilization of power in the production and maintenance of machines; 2, the crowding of the world by the biologic phenomena of accelerated production; 3, the immense accumulation of scientific knowledge; and 4, the tremendous upsurgence and steady rise in average education. It is not compulsory health insurance or state medicine that will destroy free and competitive medical practice; it is an extension of institutional medicine for which the State will provide the funds."

Dr. Heyd mentioned a number of major problems, which in his judgment, should be solved. For example: The question of medical indigence—a condition untouched and unanswered in all systems of compulsory health insurance—is constantly before the profession. Are we ready to accept any of the following propositions?

1. That every practitioner believes that the proved indigents are entitled to medical service free of all charges, and the cost of this service should be paid by taxes levied on the general population.
2. That indigence is a local problem, and should be handled only as such.
3. The extension of medical services to the indigents in their homes and the doctors' offices, with remuneration to the physician on a capitation basis.
4. The certification of indigents under the Department of Welfare with proper representation from the county medical society.
5. A medical census of the indigents to prevent padding of the lists.
6. A limitation of the number of indigents that may attend any one clinic.
7. The payment of a fair remuneration to all physicians working in out-patient departments or giving medical services to the indigents in their homes.
8. The unequivocal opposition to all forms of compulsory health insurance.

Dr. Heyd stressed a recent event in regard to health insurance in British Columbia. Both the British Columbia Medical Association and the Canadian Medical Association laid down the principles that they felt should be included in such a law. When the time came for enactment, it was discovered that the government refused to assume any financial responsibility or appropriate any money for the care of the indigents. When the great majority of physicians refused to coöperate under these new restrictions, the Premier promptly issued instruction to postpone operation of the law.

In conclusion, Dr. Heyd said:

"There rests on the medical profession one obligation that is superlative to all others. We have received from the past the splendid edifice of modern medicine. It is our natural duty to hand that on to generations yet to come, with the splendid spirit of science and the spirit of loyalty. The ranks of organized medicine must stand fast, and must speak unanimously with one resonant voice, so that medicine shall be free to explore the unheralded realms of science and march forward with increasing effectiveness. Hundreds of years ago it was stated that 'Where there is no vision, the people perish'."

EXHIBITS

Our mammoth Convention Hall was crowded with very interesting exhibits and the Scientific Exhibit was larger, more comprehensive and, if possible, a much more instructive feature of the meeting than ever before.

NEW OFFICERS

The following officers were elected:

President, Dr. J. H. J. Upham, Columbus, Ohio
President-Elect, Dr. Irving Abell, Louisville, Kentucky
Vice-President, Dr. Junior B. Harris, Sacramento, California
Treasurer, Dr. Herman Kretchmer, Chicago, Illinois
Secretary, Dr. Olin West, Chicago, Illinois
Speaker of the House, Dr. N. B. Van Etten, New York City
Vice-Speaker, Dr. H. H. Shoulders, Nashville, Tennessee

Cleveland and Atlantic City presented invitations for the meeting in 1939. San Francisco was selected without opposition for the meeting place in 1938.

Dr. Walt P. Conaway, *Chairman*
Dr. Ephraim Mulford
Dr. Blase Cole
Dr. Hilton S. Read for Dr. Wells P. Eagleton

THE PUBLIC RELATIONS COMMITTEE

By J. H. Kler, M.D., Chairman

On Sunday, June 27, 1937, the Public Relations Committee held a meeting just before that of the Welfare Committee and thoroughly discussed its program for the coming year. The success of the past year warrants the continuation of the program outlined in our report to the House of Delegates. However, experience indicates certain changes and modifications. The following activities are planned:

1. SPEAKERS' BUREAU, STATE AND COUNTY

Both the State and the County Bureaus are to be organized in a similar manner. The State Speakers' Bureau is to be under the supervision of the Chairman of the State Public Relations Committee; and the County Speakers' Bureaus will be under the direct supervision of the Chairman of the Public Relations Committee of each component county.

The Woman's Auxiliary will be responsible for the arrangement for meetings; but the speakers are to be assigned by the Chairman of each County Public Relations Committee. The Auxiliary members are not to contact speakers directly. This will place the responsibility for securing *audiences* upon the Woman's Auxiliary and the responsibility for supplying appropriate *speakers* upon the County and State Societies.

In order to aid the speakers in preparing their addresses, the State Committee will supply folders containing an outline of an address, and address itself, and a prepared news release of the address. These addresses are to be used as models, or as prepared. To those members who prefer to prepare their address entirely, folders containing Hygeia loan collections will be sent.

This method should reduce the work placed upon speakers to a minimum. The general scope of addresses will be retained; i. e., addresses to P.-T. A. groups are on the various problems of child health. Addresses to Service Clubs are on health problems peculiar to women. There are no talks specifically on Medical Economics unless requested. However, there is an indirect but definite reference to this subject in every address by emphasizing the fact that all accomplishments in the reduction of mortality have been due to the unhampered activity of the profession. Each address points out, in a few words, the unselfish philosophy of the profession.

2. THE PACKAGE LIBRARY

Various health topics are included in the package library:

a. Bulletins from the committee as described above.

b. Hygeia loan collections on many varied topics are available.

c. Various short addresses and radio talks.

d. Information on medical economics available to responsible lay organizations.

3. NEWSPAPER PUBLICITY

The press is one of our most valuable aids. We have the enthusiastic support of the influential editors. We must develop our plans carefully. We also realize the dangers of certain types of publicity. It is necessary that we modify our views toward the press; but at the same time we must protect our integrity by proper supervision of publicity matter. In short, we need to pick our spokesmen as well as the material released. Through the mutual coöperation of the Society and the press, this can be accomplished. We have learned that the press can be trusted to carry out their part.

4. RADIO BROADCASTS

Several new ideas are introduced, and if they can be developed, an unusual program will be offered. Progress will be reported later.

5. LIBRARY BOOKS

Each County Medical Society needs to appoint a committee to advise librarians on "Health books and magazines".

6. CONTACTING LAY HEALTH ORGANIZATIONS

Most lay organizations have some special "health" interest. If we demonstrate a genuine and friendly interest in their work, they will reciprocate. Only then can we expect active coöperation. Through the Auxiliary we have a close contact with the various women's organizations; and through our own membership we have close contacts with all service clubs and most fraternal and professional groups. These organizations represent the intelligent and active leaders of our communities. They will carry our messages to every home.

7. CONTACTING LEGISLATORS

We need the friendly attitude of our Legislators, both State and Federal, and they in turn need our advice on many legislative matters. It is essential that we maintain a friendly relationship. Most legislators are flooded with all forms of communications. We believe that our messages should be pertinent and brief, and represent both sides of all controversial matters. Here, more than anywhere else, we must deal in principles, and not in personalities.

8. STATE-WIDE HEALTH DAY

A "Health Day" needs further consideration. It is an excellent idea and can be presented as soon as we secure exhibit material. There are many requests from various groups for exhibit material. To be able to supply it will be in keeping with the activity of our Society.

9. PARTICIPATION IN STATE-WIDE PROGRAMS

Through participation in all State-wide health programs, we can lead most effectively in the development of a more effective program of distribution of medical services. Here we demonstrate our social consciousness, and apply our professional skill. Unguided or poorly guided health programs breed socialization of medical care.

10. CO-OPERATION WITH VARIOUS COMMITTEES

The work of every committee can be publicized. We have the machinery and the organization. All that is necessary is to present the matter through official channels to assure uniformity of action. May we urge all committees to avail themselves of the services of the publicity department of the State Society.

In the development of this broad program, it is essential that it be informative and educational for the profession as well as the public. Instructional meetings in each county to present details of the State Society activity seem most worthwhile. These meetings are most effective when they translate the *mass* activity of the State Society into the *personal* contacts which are possible in a local group.

VITAL STATISTICS—REPORTS OF BIRTHS

The Bureau of Vital Statistics of the Department of Health of the State of New Jersey has a simple system for reporting and recording all births that occur in the State. The State Department of Health provides the blank forms on which the reports are made, and issues them free in bound booklets.

1. A NORMAL BIRTH

The basic form is that concerning the newborn child and its parents. This is the familiar form which is issued in booklets, each containing twenty blank certificates. This report is to be made by the doctor or midwife, and sent to the local registrar, who relays it to the State Department of Health.

2. DELAYED NAMING OF A CHILD

Each booklet contains eight blank forms for making a supplementary report containing the given name of the child when the child had not been named until it was five or more days old. This form may be used by either the professional attendant, or one of the parents; and is to be sent to the local registrar of vital statistics.

SUPPLEMENTAL REPORT OF BIRTH CONTAINING NAME OF CHILD

Full name of child .....
Place of birth .....
Date of birth .....
Full name of father .....

.....
(Signature of professional attendant or parent)

.....
Address

3. VISIBLE CONGENITAL DEFORMITIES

Each booklet contains two blanks for reporting "Visible Congenital Deformities" in compliance with the "Birth Reporting Law", chapter 34, Laws of 1932. When the new-born child has a crippling deformity, that defect is to be reported on the blank, and sent to the "State Crippled Children's Commission", State House, Trenton, New Jersey.

Note that the report is not to be sent to the local registrar, nor to the State Department of Health; but to the State Crippled Children's Commission.

The face of the blank is as follows:

Blank for REPORTING VISIBLE CONGENITAL DEFORMITIES

This form to be completed and mailed to
STATE CRIPPLED CHILDREN COMMISSION
State House, Trenton, N. J.

Full name of Child .....
Date of Birth .....
Name of Father
(or Mother) .....
Address .....
Type of deformity .....
(Check on Reverse Side)
Has child received attention for deformity by attending physician? .....
If so, give name .....
and address of physician .....
Has child been referred to Orthopedic surgeon? .....
If so, give name .....
and address of surgeon .....
Signature of professional
attendant or parent .....
Address .....

(See other side)

The back of the blank numerates the deformities which are usually encountered, and is as follows:

TYPE OF DEFORMITY SHOULD BE CHECKED IF POSSIBLE

If not listed, include at end.

Absent organ, part or bone
Designate structure

Amputation—Intrauterine
Designate part

Ankylosis of joint. (stiffness)
Fibrous or bony

Brachial Paralysis
Right, left or bilateral

Cerebral Compression
Cerebral Hemorrhage
Cerebral Meningocele

Cleft Foot
Right, left or bilateral

Cleft Hand
Right, left or bilateral

Cleft Palate

Club Hand
Right, left or bilateral

Coloboma

Contracture of Joint
Designate joint

Deficiency of bone
Designate bone

Dislocation
Designate joint

Elevation of scapula
Right, left or bilateral

Epispadias

Extrophy of bladder

Fracture—Intrauterine
Designate part
United or ununited

Fragilitas Ossium

Hallux Valgus

Hammer Toe

Hare Lip
Unilateral or bilateral

Hernia
Designate type

Hydrocephalus

Hypospadias

Imperforate Anus

Imperforate Urethra

Polydactylism (accessory finger or toe)
Fingers or toes

Scoliosis (spinal curvature)

Spina Bifida
Area involved

Strabismus (wall or cross eye)
Internal or external
Right, left or bilateral

Supernumerary parts
Designate parts

Syndactylism (webbed fingers or toes)
Fingers or toes

Synostosis
Designate bones

Talipes (Club foot)
Calcaneo valgus
Calcaneus
Cavus
Equino valgus
Equino varus
Valgus
Varus
Right, left or bilateral

Torticollis (wry neck)
.....
.....
.....

The legal responsibility of the attending physician for the defect ends when he has sent his report. However, there remains a moral responsibility that he shall coöperate with the State Crippled Children's Commission in trying to correct the defect. Moreover, the Commission will assist the physician in every possible manner, and help to provide hospitalization, nursing apparatus, and other facilities necessary for the treatment and support of the child.

4. STILL-BIRTHS

Each booklet of birth forms includes one blank for reporting a birth in which the child is born dead. If a child is born alive, but breathes only once or twice, it is to be reported as both a live birth and a death. The blank is similar to the blank for living children, except that it is printed on yellow paper.

5. BIRTH CERTIFICATE OF AN ADULT

It is only in comparatively recent years that birth reports have been required; and still more recently that the law has been upheld by public sentiment and enforced by public officials. A considerable number of adult persons have therefore been unable to establish their ages by legal proof. In order to correct this condition, the laws of New Jersey provide a simple method by which a person may have an official record of his birth placed on the files of the

Department of Health, subject to the limitation that an older person must certify to the facts from actual observation and experience.

The face of the blank that the State Department of Health supplies to an adult for recording his own birth is as follows:

Form 1 b V. S.

SEE REVERSE SIDE FOR EXPLANATION; BOTH SIDES MUST BE COMPLETED.

PLACE OF BIRTH STATE DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS

County ..... State .....New Jersey ..... Registered No. .....

Township ..... or Borough ..... or

City ..... No. ....., ... St., ... Ward

FULL NAME OF CHILD

SEX	Twin, triplet, or other..... Number, in order of birth.....	Legitimate?.....	Date of birth....., 1.....

FATHER	MOTHER
FULL NAME	FULL MAIDEN NAME
RESIDENCE (When child was born)	RESIDENCE (When child was born)
COLOR OR RACE / AGE WHEN CHILD WAS BORN	COLOR OR RACE / AGE WHEN CHILD WAS BORN
BIRTHPLACE	BIRTHPLACE
OCCUPATION (When child was born)	OCCUPATION (When child was born)

PENALTY FOR FALSE CERTIFICATE $500.00

(Signature) .....

Address .....
(Street and Number) (City and State)

Date .....
(Relationship to person born)

Received ....., 19.... .....
Registrar.

Reverse Side Must Also Be Completed

Note below who is authorized to take the affidavit.

AFFIDAVIT

STATE OF .....
COUNTY OF ..... } ss.

....., being duly sworn, says that (s)he has definite knowledge of the facts concerning this birth and that all information shown on the certificate is true and correct.

NATURE OF KNOWLEDGE OF FACTS OF BIRTH .....

Signature of Affiant .....

Subscribed and sworn to before me this ..... day of ....., 19....

Signed .....

*Official Title .....

*The affidavit must be taken before the judge of the Court of Common Pleas of the county where the birth occurred or a judge having similar powers in the county where the person making the affidavit resides.

The person who is authorized to sign this certificate is either:

1. The physician or midwife who was in attendance at the birth.

2. Either parent of the child.

3. Any person who knows the facts from personal observation, such, for example, as that he was a neighbor and saw the baby grow up and be treated as the child of its guardians.

The affidavit which is printed on the back of the certificate must be executed under certain conditions which are printed on the certificate as follows:

Any birth which occurred since April 16, 1909, can be reported over the signature of the physician, midwife or person acting as midwife who was in attendance upon the birth or over the signature of either parent of the child without affidavit. An affidavit is necessary when it is impossible to obtain such a signature.

An affidavit is also required to record a birth which occurred prior to April 16, 1909, when it is impossible to obtain a certificate over the signature of the attendant at the birth.

The birth certificate may be signed by any person who has definite knowledge of the facts concerning the birth. The relationship, if any,

to the person whose birth is being reported should be stated.

PRACTICAL DIRECTIONS TO THE DOCTOR

1. No affidavit is required when the report is signed by the doctor, midwife, or other person who was in actual professional attendance upon the mother at the time of the birth of her child.

2. No affidavit will be required if the certificate is signed by either parent, and the birth occurred later than April 16, 1909.

3. An affidavit will be required from the parent who signs the certificate, if the birth occurred before April 16, 1909.

4. An affidavit is required when the person signing the certificate is neither a parent, nor a professional attendant at the birth.

When an affidavit is required, it is to be signed by the same person that filled out the certificate of facts.

The certificate of birth issued to an adult is to be filed with the local registrar, and be forwarded by him to the State Department of Health, so that the record will be available in two places.

CONNECTICUT CLINICAL CONGRESS

The annual Clinical Congress of The Connecticut State Medical Society, which was attended last year by 633 physicians from ten states, will be held this year in New Haven on Tuesday, Wednesday, and Thursday, September 21, 22, and 23. The registration fee for the entire Congress will be $2.00. The morning sessions, beginning at 9:30, will be held in the auditorium of the Sterling Law Buildings. The afternoon and evening sessions, beginning at 2:15 and 8:15, respectively, will be held in the buildings of the New Haven Hospital and the Yale School of Medicine. The evening meetings are section meetings which are open to all members of the Congress. New Jersey physicians are cordially invited to register.

The program on Tuesday is as follows:

1. Cranial Trauma, Dr. F. C. Grant, Philadelphia, Pa.
2. Treatment of Early Syphilis, Dr. J. E. Moore, Baltimore, Md.
3. Treatment of Burns with Aniline Dyes, Dr. R. H. Aldrich, Boston, Mass.
4. The Place of the Cesarian Section, Dr. F. C. Irving, Boston, Mass.

On Tuesday afternoon the subjects of the morning will be illustrated with bedside clinics; and will also be debated in a series of "Panel Discussions". The session on Tuesday evening will be on syphilis and cancer.

The program for Wednesday morning is as follows:

1. Surgical Diseases of the Extra-Hepatic Bile Ducts, Dr. Isidor S. Ravdin, Philadelphia, Pa.
2. Treatment of Various Types of Anemias, Dr. William B. Castle, Boston, Mass.
3. Clinical Experience with Radium and X-Ray in the Treatment of Cancer, Dr. Emil Novalk, Baltimore, Md.

On Wednesday afternoon the speakers at the morning sessions will conduct clinics on the subjects of the morning.

The program on Wednesday evening will be on the general subject of anesthesia, and will include resuscitation, and analysis of anesthetic conditions.

On Thursday morning the subjects for discussion will be the treatment of psychoneurotic disorders; fracture deformities of the upper extremities; and the treatment of coronary sclerosis by grafting a new blood supply to the heart.

In the afternoon, coronary sclerosis, Bright's disease, and low back pain will be discussed, and a symposium on psychiatric conditions will be conducted. In the evening the discussions will be continued.

Dinners and social functions will be held.

A complete program and a registration card may be obtained from the Chairman on Publicity, Dr. M. B. Strauss, 41 Trumbull Street, New Haven, Conn.

CONTACTS AND COMMENTS

The A. M. A. Journal of June 1, 1935, page 2001, records a decision of the United States Supreme Court upholding the Oregon law forbidding exaggerated forms of dental advertising, especially that of claims for actual superiority in dental skill. The decision is contained in the case "Semler vs. Oregon State Board of Dental Examiners" (55 Sup. Ct. 570).

In this case the defendant dentist claimed that his skill and methods were in fact real; but the Supreme Court said:

"We do not doubt the authority of the State to estimate the baleful effects of such methods, and to put a stop to them. The legislature was not dealing with trades in commodities, but with the vital interest of public health; and with a profession treating bodily ills and demanding different standards of conduct from those which are traditional in the competition of the market place. The community is concerned with the maintenance of professional standards which will insure not only competency in individual practitioners, but protection against those who would prey upon a public peculiarly susceptible of imposition through alluring promises of physical relief.

"The legislature was entitled to consider the general effects of the practices which it described; and if these effects were injurious in facilitating unwarranted and misleading claims, to counteract them by a general rule, even though in particular instances there might be no actual deception or misstatement."

The Journal concludes the article with the statement:

"The success of their efforts (referring to the dental law passed by the efforts of the dentists) should encourage the medical profession to seek similar legislation where present advertising privileges are abused."

In a foot-note the A. M. A. Journal gives the following lists of States which have passed laws similar to that of Oregon during 1933, 1934, and up to June, 1935: Delaware, Illinois, Maryland, Wisconsin, Massachusetts, Rhode Island, California, Colorado, Idaho, Indiana, Iowa, Maine, Montana, New Hampshire, Tennessee, and Utah.

The A. M. A. overlooked the law passed by the Legislature of New Jersey and approved April 20, 1934, which provides grounds for the revocation of a license to practice dentistry on seven grounds, the last one being:

"Has advertised in any manner his products, or the price or charge to be made, or the character or durability of his works or products, or anything identical to any of the foregoing, whether by means of circular, card, sign, poster, advertising matches, mirrors, or other articles, or by advertisements in newspapers, magazines, or other publications, or by projection by means of light or by crier or radio broadcasting, or by use of advertising solicitors or publicity agents; or has permitted the use of his name as a dentist by others in the sale or advertisement of products".

This law was enacted by the efforts of the dentists themselves who filled the gallery of the Assembly during the session at which the law was passed, and made known their attitude in no uncertain manner.

Dr. Wilkes has just received the following letter of appreciation from a physician in Jersey City:

"I received the windshield emblem of the State Medical Society the other day, and wish to express my thanks to you for this unsolicited service. I have seen them on the cars of my fellow-members, and several times I have been on the point of requesting them.

"I also appreciate the suggestion of applying one to the door between my waiting room and consulting room. As you stated in your letter, I have found that being a member of the A. M. A. weighs heavily with certain patients. This is an ethical and unobstrusive way of calling it to their attention."

The following letter of appreciation has been received from Mr. Joseph E. Alloway, Executive Director of the Board of Children's Guardians of the State of New Jersey, by Dr. Daniel Featherston, Secretary of the Monmouth County Medical Society:

"May I take this occasion, on behalf of the Board of Children's Guardians, to thank the Monmouth County Medical Society for its splendid coöperation in organizing its members in the service of our dependent children. We understand it is satisfactory for the new charges of $1.00 and $2.00 to be made effective as of July 1.

"We wish also to express our appreciation to the individual physicians who have offered their services to these children, agreeing to the above concession in the matter of charges. This is only another instance of the ready response of the Monmouth County physicians in meeting the health needs of their communities."

The meeting of the Hunterdon County Medical Society is the last one on the scheduled list of meetings of the County Societies during the year. Its meeting on July 27 was attended by three-fourths of its listed membership, who gave abundant evidence of their deep interest in the problems which confront the practitioner of medicine in these modern days.

The program of the meeting consisted of two principal features. First was a consideration of the duties of a "Field Physician", which were clearly explained by Dr. Wilkes, Executive Officer of the State Society (see editorial, page 482). The essential feature of the work of the Field Physician is to be a liaison officer between the local physicians and the government officials who will *assist* the local physicians in their private practice in maternal welfare and child hygiene. The plan is that the County Society shall nominate two or three of its own members for the position, one of whom shall be appointed by the State Department of Health and paid a modest sum for his services. His duties shall be educative and stimulative, and particularly to be ready to help the local physicians to secure assistance in professional and welfare lines in cases of need.

Hunterdon County is more nearly rural than any other county in the State, and the physicians have the opportunity to develop modern methods of practice along lines of their own choosing.

Another pleasing feature of the Hunterdon County meeting was the presentation of keys and certificates to three of its members who have been a half century or more in practice (see page 537).

A survey of the practice of medicine in Hunterdon County is in process of writing, and will be published in the September Journal as the first of a series which is planned by the Publication Committee. There is a tendency to judge the efficiency of a county society by a comparison of it with larger societies whose problems are of a different nature because of economic and social conditions. Hunterdon County offers an opportunity to present a survey of a field in which the medical profession is free to develop its own method of service with a minimum of interference from outside agencies.

The Essex County Medical Society, with 800 members and all the facilities of great centers of population, is developing its "Bulletin" into a model organ of the local medical profession. It has its plans well under way, and will initiate its new system in the near future. Its enlarged Bulletin will be an efficient means of bringing its activities to the attention of not only its own members, but to physicians throughout the State.

Essex County has its own problems, which are similar to those in rural communities, but magnified by the great "Diversity of gifts" of its members. A practitioner of medicine in a great city can be "Individualistic" to a far greater degree than one in a rural community, whose every act is open to public comment. Yet the principles of practice and of relationships in it are the same as those in a rural county. Its great advantage is the large number of its public-spirited leaders whose influence is recognized by the great majority of practitioners.

The article on "The Reporting of Births", on page 530, may seem to be trite and commonplace; yet how many physicians know whether or not their own births are recorded? and how to have an official record of that event made? A birth record, for example, is necessary for travel in a foreign country. The process of recording the birth of an adult in New Jersey is simple, and every doctor will profit by making sure that his own birth is recorded.

The Scientific Exhibits were among the most practical and valuable features of the Annual Meeting of The Medical Society of New Jersey. Following the precedent of last year, the Trustees have authorized the publication of illustrated articles describing the more striking exhibits. The first installment appears in this Journal, beginning on page 510, and is on the general subject of "Ovarian Functions". The articles are really scientific outlines of common conditions. The series will be continued in future issues.

The Committee on Pharmaceutical Relations has introduced a new feature beginning on page 505 of this issue of the Journal. The committee has chosen the new drug, sulfanilamide, as its subject, and has treated it in a scientific manner.

It is planned that the articles shall be of a practical nature, and similar to those on "Maternal Welfare", which have now reached number eighteen of the series. The series on pharmaceutical relations should prove to be of equal value, for every physician prescribes drugs daily.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

J. Carlisle Brown, M.D., Secretary

The annual meeting of the *Atlantic County Medical Society* was held May 14th, 1937, at the Ambassador Hotel, Dr. John S. Irvin presiding. Seventy-two members and guests were present.

TUBERCULOSIS CARE

A motion was unanimously passed that this society go on record as recommending that a modern institution for the care of tuberculous patients be erected in Atlantic County.

BROADCASTING

A committee will be appointed to attend a conference with the executives of the Press-Union Publishing Co., at which their application for a broadcasting station will be discussed. The committee will have the power to decide whether the society will be in favor of endorsing such a station.

Two motions made by Dr. Stern with regard to unethical advertising, exhibiting, and broadcasting were lost.

AMERICAN THERAPEUTIC SOCIETY

Notice was given of the meetings of the American Therapeutic Society to be held at the Hotel Traymore June 4th and 5th. A joint meeting with this society will be held June 5th at 9 p. m.

WINDSHIELD INSIGNIA

A definite ruling will be made later with regard to the windshield insignia when a final check has been made of this problem.

NEW MEMBERS

Drs. F. Rolfe Westney and J. William Hughes, Jr., were unanimously elected to active membership in the society upon recommendation of the Board of Censors.

INSURANCE

Dr. Allman read a letter from the Atlantic City Association of Insurance Agents stating that all benefits as outlined in the plan of the State Society could be secured through local insurance brokers.

A. M. A. MEETING

Reports of the Committee on Local Arrangements for the Annual Meeting of the American Medical Association were made, and Dr. Carrington urged every member of the society to devote every possible effort to making this convention the biggest and the most successful in its history.

ECLAMPSIA

Dr. Brown, reporting for the Maternal Welfare Committee, stated that a round-table discussion of eclampsia would be held Tuesday, May 25th, at the Atlantic City Hospital, and urged the members interested in obstetrics to attend.

RAGWEED CONTROL

The Ragweed Control Committee, reported by Dr. Hyman, is making progress.

FINANCIAL

Drs. Davidson and Stalberg were appointed auditors of the Treasurer's accounts.

On motion, the dues for this society for 1938 were fixed at $18.00.

A motion was made to strike out entirely Chapter V, Section V, of the By-Laws, and to make an amendment stating that the fiscal year of the society shall be from May 1st to April 30th, inclusive.

SOCIAL SERVICE WORKERS

Dr. Barbash reported that the Superintendent of the Atlantic City Hospital requested that nothing be done with regard to extra social service workers until the Fall, and expressed the hope that the work could be carried on satisfactorily.

ELECTION OF OFFICERS

The following officers were elected:

President, Hilton S. Read, M.D.
Vice-President, James H. Mason, 3rd, M.D.
Treasurer, David B. Allman, M.D.
Secretary, J. Carlisle Brown, M.D.
Reporter, E. H. Nickman, M.D.
Historian, H. L. Harley, M.D.

Delegates: D. W. Scanlon, M.D.; David B. Allman, M.D.; John S. Irvin, M.D.
Alternates: Karl Scott, M.D.; Philip Marvey, M.D.; Andrew M. Smith, M.D.

Nominating Committee: D. W. Scanlon, M.D.
Alternate: Karl Scott, M.D.

Board of Censors: John S. Irvin, M.D.

Delegates to Other Societies: W. E. Darnall, M.D.; V. E. Johnson, M.D.; H. I. Silvers, M.D.; Norman Bassett, M.D.; Benjamin Gordon, M.D.; Myrtile Frank, M.D.

A vote of thanks was extended to the Ambassador Hotel for the very fine treatment the society has received the past year.

Dr. Andrews announced the Martin Johnson lectures on June first.

HUNTERDON COUNTY

E. W. Lane, M.D., Secretary

The *Hunterdon County Medical Society* met on July 27th at the New Jersey State Sanatorium, Glen Gardner, with the following present:

Drs. B. S. Fuhrmann, President; E. W. Lane, F. A. Thomas, G. B. Tompkins, J. J. Cartisser, A. H. Coleman, E. W. Closson, S. B. English, B. M. Harman, T. B. Fulper, I. R. Boothby, P. H. Baker, Francis Apgar, and C. H. Boyer.

Visitors: Drs. Raymond Germain, LeRoy A. Wilkes, J. Bennett Morrison, Frank Overton, George N. J. Sommer, and Mrs. Sommer.



Doctors present at the Hunterdon County Medical Society, July 27th, 1937, at Glen Gardner.

1. Barclay S. Fuhrmann, Flemington
2. R. Farley, Glen Gardner
3. Samuel B. English, Glen Gardner
4. E. E. Cioffe, Glen Gardner
5. I. R. Boothby, Clinton
6. F. Landry, Glen Gardner
7. E. W. Closson, Lambertville
8. C. G. Boyer, Annandale
9. Philip W. Baker, High Bridge
10. G. N. J. Sommer, Trenton
11. J. J. Cartisser, Sergeantsville
12. J. B. Morrison, Newark
13. R. J. Germain, Glen Gardner
14. F. A. Apgar, Oldwick
15. Max Gross, Glen Gardner
16. LeRoy A. Wilkes, Trenton
17. T. B. Fulper, Hampton
18. F. A. Thomas, Flemington
19. G. B. Tompkins, Flemington
20. A. H. Coleman, Clinton
21. E. W. Lane, Bloomsbury
22. B. N. Harman, Frenchtown



Drs. Closson and Apgar

HALF CENTURY OF PRACTICE

President Fuhrmann, on behalf of the Society, recognized three members who had been in practice for fifty or more years:

Francis Asbury Apgar, Oldwick, graduactd from Bellevue Medical School, 1876.

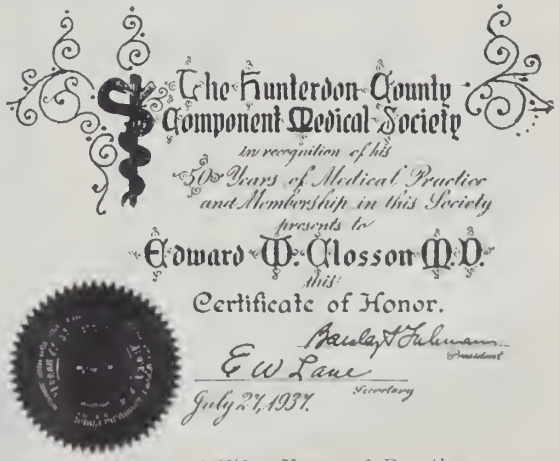
Harry M. Harman, Frenchtown, graduated from Jefferson Medical College, 1887.

Edward W. Closson, Lambertville, graduated from New York University, 1885.

Dr. Fuhrmann presentcd to each of thc honored members a golden key, suitably engraved, and a certificate of membership. Dr. Byron M. Harman, Medical Director of Essex Mountain Sanatorium, Verona, received the tokens on behalf of his father, who was slightly indisposed and was conserving his strength for the celebration of his golden anniversary on the following day, when five physician members of the family, and several who are preachers, would be present.

HONORARY MEMBERS

On motion by Dr. Boothby, the Society voted to make Drs. J. Bennett Morrison and Frank G. Scammell Honorary Members.



Certificate of Fifty Years of Practice

SUMMER ROUND-UP

Dr. Fuhrmann read a letter from Dr. Stanley Nichols, Chairman of the Sub-Committee on Public Health, concerning the *Summer round-up*. It was the concensus of the society that this question could best be handled by the family doctors and the school physicians.

VENEREAL DISEASE CONTROL

A letter was read from the Hunterdon County Welfare Workers Committee in reference to Venereal Disease Control work. It was moved and seconded that the society go on record as favoring the picture film entitled "Damaged Lives" as a part of this work.

FIELD PHYSICIAN

President Fuhrmann called attention to the position of "Field Physician" for Hunterdon County, under the Bureau of Maternal and Child Health of the State Department, and showed forms on which applications should be made.

Dr. LeRoy A. Wilkes, Executive Officer, explained the duties of the offices. There is a Field Physician in each county, nominated by the County Medical Society, appointed by the Department of Health, and paid from Federal Security funds.

The work of the Field Physician is essentially that of a liaison officer between the family physician and the specialists, particularly those who may be of help to him in difficult cases. (See editorial on page 482.) He is not to be a teacher of obstetrics, or a critic of the family doctors. His duties are essentially two-fold:

1. To explain the means which the State Department of Health and the Federal Security officials place at the disposal of family doctors.

2. To discuss with the family doctor the reasons for the unsatisfactory result in any maternity case, and to point out ways of avoiding its repetition in future patients.

MONMOUTH COUNTY

O. R. Holters, M.D., F.A.C.S., Reporter

The regular monthly meetings of the *Monmouth County Medical Society* have been suspended for the Summer but, however, a dinner was held at the Deal Country Club on the evening of June 23rd. The dinner was exceptionally well attended by the doctors of the county, and there were present, as their guests, many of the dentists and lawyers of Monmouth County.

The dinner was presided over by Dr. Byron Blaisdell. The main speakers of the evening were Dr. William G. Herrman, President of the State Medical Society; and Mr. Theodore Parsons, of Red Bank, who gave a discourse on the closer relationship of the medical and legal professions.

United States District Attorney of the State of New Jersey John J. Quinn was also to have been a guest speaker, but due to the Parker trial did not arrive in time to speak.

During the afternoon preceding the dinner, sports were indulged in by many of the athletically inclined! A golf tournament was held, at which the victors were Dr. Martin Quirk, Dr. John Maher, and Dr. Leon Reisner.

There was also a baseball contest between the married and unmarried doctors.

Following the dinner, some of the boys assembled at the round table, and plied each other with poker until the "wee" hours of the morning.

We are very sorry to announce the death of Mrs. Clara Strauss, mother of Dr. Arthur Strauss, of Long Branch, who died on June 16th, 1937.

We regret to announce, also, a mishap to Dr. Frank Altschul, of Long Branch, who fractured his left humerus during a course on the golf field.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS DURING THE YEAR ENDING JULY 1, 1937

DIPHTHERIA TOXOID

County	To May 31	Month of June	Total to June 30	Average per Month
Atlantic	1061	64	1125	93.7
Bergen	1646	470	2116	176.3
Burlington	1029	97	1126	93.8
Camden	898	373	1271	105.9
Cape May	378	13	391	32.6
Cumberland	287	39	326	27.1
Essex	10339	980	11319	943.2
Gloucester	344	13	357	29.7
Hudson	168	6	174	14.5
Hunterdon	292	224	516	43.
Mercer	47	11	58	4.8
Middlesex	2532	286	2818	234.8
Monmouth	756	179	935	77.9
Morris	407	123	530	44.1
Ocean	358	59	417	34.7
Passaic	4746	955	5701	475.1
Salem	280	198	478	39.8
Somerset	1595	169	1764	147.
Sussex	126	25	152	12.6
Union	2513	1440	3953	329.4
Warren	558	36	594	49.5
Totals	30360	5761	36121	3010.1

SMALLPOX VACCINE

County	To May 31	Month of June	Total to June 30	Average per Month
Atlantic	522	57	579	48.2
Bergen	1234	1104	2338	194.8
Burlington	265	14	279	23.2
Camden	586	153	739	61.5
Cape May	69	14	83	6.9
Cumberland	466	37	503	41.9
Essex	4672	918	5590	465.8
Gloucester	328	28	356	29.6
Hudson	83	6	89	7.4
Hunterdon	265	214	479	39.9
Mercer	81	8	89	7.4
Middlesex	871	205	1076	89.6
Monmouth	1663	187	1850	154.1
Morris	1032	176	1210	100.8
Ocean	261	103	364	30.3
Passaic	2508	609	3317	276.4
Salem	34	10	44	3.6
Somerset	66	6	72	6.
Sussex	122	0	122	10.1
Union	1285	168	1453	121.1
Warren	640	78	718	59.8
Totals	17053	4297	21350	1797.1



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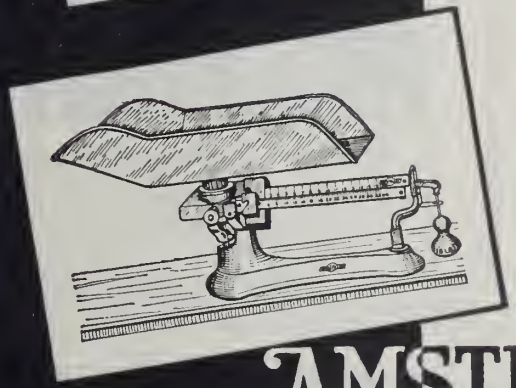
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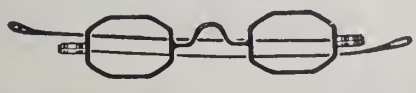
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	Parts per Million	Grains per U.S. Gallon
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Manganese (Mn)	None	None
Calcium (Ca)	13.7	0.80
Magnesium (Mg)	5.8	0.34
Sodium (Na)	5.6	0.33
Potassium (K)	Trace	Trace
Bicarbonic Acid, Radical (HCO_3)	43.1	2.52
Carbonic Acid Free (CO_2)	7.0	0.41
Sulphuric Acid, Radical (SO_4)	27.1	1.58
Nitric Acid Radical (NO_3)	1.8	0.11
Chlorine	4.2	0.25
Phosphorus	Trace	Trace
TOTALS	128.9	7.54
Cubic centimeter N/10 Acid to neutralize one litre (methyl orange indicator)	7.06	
Hydrogen Ion concentration, pH		
As received	6.8	
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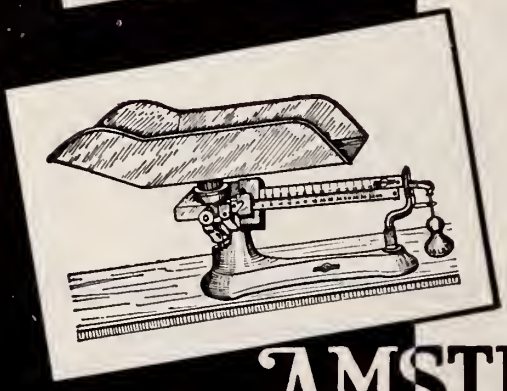
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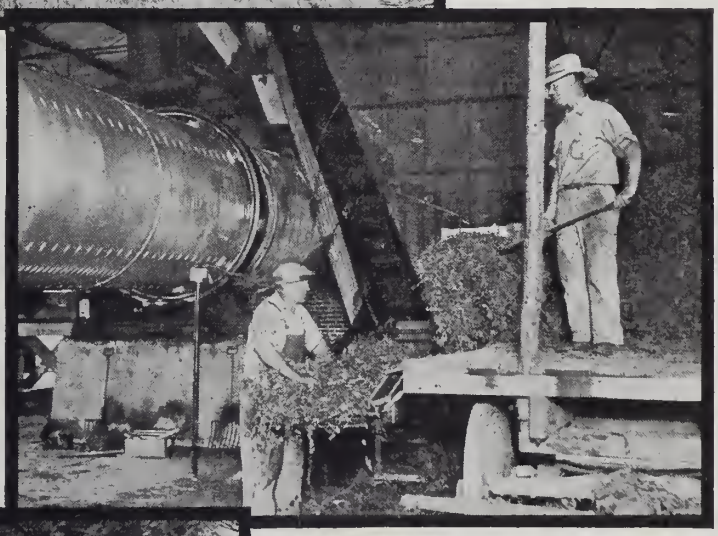
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[1] Cole, Harold N., *et al.; J. A. M. A.* 108:22, 1937.

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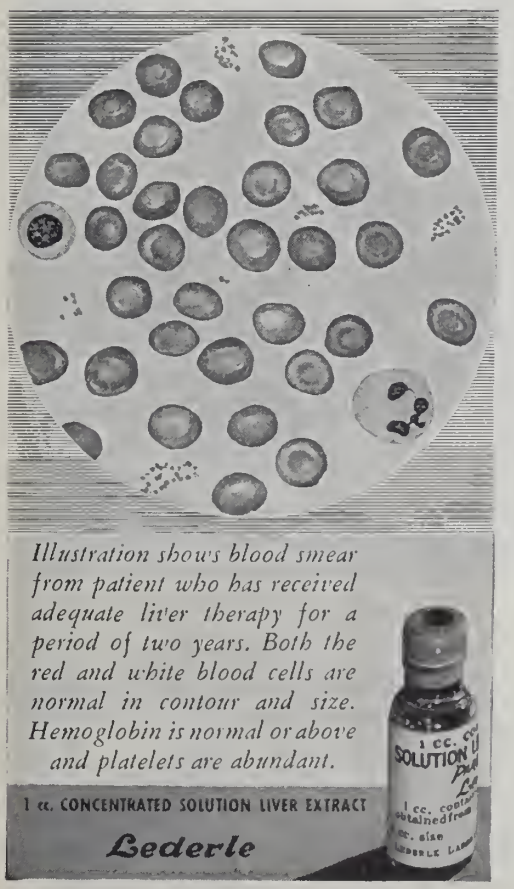


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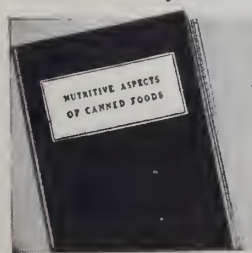
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Volume XXXIV.
Number 9

THE JOURNAL
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EDITORIALS

Unity of Medical Service

Every physician is a member of the volunteer army of guardians of health in all its phases, private and public. He cannot afford to divorce his private practice from that of public health; for when he does so, other agencies are ready to displace him from even his private practice.

ASSISTANTS OR COMPETITORS

The physician practicing *curative* medicine and surgery has assistants,—nurses, technicians, hospital directors, welfare workers, school teachers, and spiritual comforters,—who accord him the respect and obedience which he rightfully expects and demands,—for they recognize his superior knowledge and skill. Yet the physicians practicing *preventive* medicine sometimes finds these assistants to be his *competitors* as they attempt to diagnose menaces to health, and to prescribe measures designed to prevent sickness and to promote bodily vigor and resistance to disease.

THE MEDICAL SOCIETY

Physicians have voluntarily subjected themselves to a high degree of discipline and organization by means of their *medical societies,* whose principal object has hitherto been to establish and enforce standards for the practice of *curative* medicine. These standards are of two classes:

1. Those dealing with the scientific principles of diseased conditions, and their recognition and treatment.

2. The mutual relations between the physician and those rendering accessory services; and the action to be taken by each group.

Medical societies are now engaged in developing similar standards of practice in the newer field of *preventive medicine.* All groups of health workers are willing to credit physicians with the leadership in developing the scientific principles on which the practice of preventive medicine is founded. The leaders of the medical societies of the counties and State are now engaged in the equally difficult task of defining the fields of action which properly belong to each group of workers; but in doing so, they need first to define the work which they themselves shall do; and second, to inspire each member to deliver the particular service which presents itself to him.

The Spirit of Service

One of the officials of our State government in a recent letter to me rather chided me for not emphasizing in public the "spirit of service" which he felt most members of the medical profession possessed, and which he felt all members of the profession should strive to exhibit. My answer, in part, was as follows:

"I rather hesitate as a physician to emphasize the 'spirit of service' in regard to my own profession, especially before a group who should so well appreciate it where it is exhibited. I furthermore rather feel that it should not be stressed perhaps as much in the future as it has been in the past. 'They also serve who only stand and wait.' The merchant who provides a useful article which is well made, which is needed by the community, sells it at a fair price, who pays his employees a living wage, and deals justly with his customers and with his creditors, exhibits to my mind a spirit of service. Too often members of the professions, whether it is law, medicine, or clergy, are expected to give more than their share of philanthropy because they are professional men and are supposed to exhibit the 'spirit of service' over and above their fellow men. I do not feel that it is right to expect this, nor to ask it. I do not feel that they should pat themselves on the chest and take credit for such over and above their fellow men. 'The laborer is worthy of his hire.' If a business or professional man is particularly skilled or able, and places that skill or ability at the disposal of his community, he is entitled to a fair return for this service, and if he gives it faithfully and well, he exhibits a 'spirit of service', even though he receives a material reward, which in turn merely shows that some one else has been willing to put forth human energy in return for his own.

"I had as a roommate in college a boy whose father was a missionary to the Indians. I have laughed many times thinking of how, when the missionary barrel arrived from home and the top was removed, some worn tam-o-shanter and half-worn corduroys were tossed to him as his reward, and how he took them behind the house, threw them in the dust of the Nebraska plains, and jumped on them, and the words he uttered were not prayers. I feel as he did, that if the people back home thought the Indian was worth saving, they should have been more willing to pay a living wage to the missionary who made the effort to save them than was exhibited by the barrel of second-hand clothes which arrived every so often. If they cared no more for the Indian than was implied by the cast-off clothes, they should not have taken credit for philanthropy and taken advantage of the missionary's 'spirit of service'.

"For this and kindred reason I have emphasized in my addresses the economic contribution of the doctor's service and have purposely put them alongside the material contribution of hospital trustees. The medical profession has exhibited a spirit of service such as have other groups of citizens; and without the spirit of service behind the efforts of all classes of society civilization will fail. I do not believe that any group should over-emphasize its own spirit of service, nor should society take advantage of any group by feeling that the self-satisfaction derived from the service rendered ought to be sufficient reward for the efforts expended."

Hardly had the ink of my signature become dry before the "spirit of service" to which this official referred was brought home to me most emphatically. I rise to bear testimony to this, and to remind our members that there are services above price, and there is a reward that cannot be measured in any material terms.

My son was recently operated on for ruptured gangrenous appendix in a city in Maine at a time when I could not be reached. Upon arrival in that city, although I found him in a good hospital and in competent hands, I felt desperately the need of consultation with some one whom I knew, and in whom I placed the highest confidence. I happened to know that Dr. Bradley Coley, of New York, was summering in Connecticut. I reached him in the evening by 'phone just after he had returned from a 200-mile automobile trip. Without any thought of personal hardship, he repacked his bag and drove 350 miles through the dark over strange roads to reach my son's bedside. With him came his wife to keep him company and to spell him in driving. After staying a day and night, and believing the boy to be out of danger, he returned home only that same night to be again aroused and told that pneumonia had set in. Again, without thought of himself, he attempted to reach the distant Maine city by a privately chartered plane, and would have done so if I had not refused to allow him to risk himself. The following day, by train and plane, he did return, and, as I pen these lines, he is devoting himself to saving this life so dear to me.

Such action and effort as Dr. Coley has made in my behalf I cannot let pass without bearing all the testimony that I can give to such a "spirit of service", one which has always been exemplified by the leaders in our profession and which all of us should struggle to attain.

The local surgeon, Dr. Frances Hanlon, and the nurses associated with him, have also lived

up to the best traditions of the profession, weighing not the time they spent or personal sacrifices they made in terms of dollars and cents in the effort to save a life. Local members of the profession have offered to drop their own work at this our busiest time of the year, and go to Maine, if such action on their part would be of any assistance to the boy, or even a comfort to my wife and myself. I cannot speak too highly of the welling up of good will and willingness to help on the part of all of those with whom I am professionally related.

These words, "The spirit of service", which I have tried to crystalize in this personal experience, should be engraved on our banner, and should not be lost sight of in these stressing times in which we struggle to attain the economic security due us.

WILLIAM G. HERRMAN.

Immunizations in a Rural Community

The medical survey of Hunterdon County, reported on page 578 of this Journal, reveals a novel attitude of its physicians toward so-called *clinics*. The physicians are heartily in favor of the public health hour for immunizing children, but the county is distinctively rural and parents have difficulty in coming to the offices of the doctors although they are willing to do so. Moreover, the physicians have difficulty in maintaining a supply of immunizing material in their offices, and in making preparations for giving the immunizations at infrequent intervals. They have therefore evolved a system whose details are as follows:

1. The children are brought to the schoolhouse, which is called an immunizing *center*,—not a *clinic*.

2. Physicians are assigned by the county society to give the immunizations.

3. Since this is a public health project, the school authorities, the public health nurses, the Red Cross members, the churches, and other organizations contribute the services of their representatives in bringing the children to the center.

4. These organizations also provide funds for paying the doctors for giving the immunizations. The pay is not large, but is satisfactory to the physicians.

5. The organizations also assign volunteer helpers to assist the doctors in giving the immunizations.

The system works satisfactorily for at least four reasons:

1. It is promoted by the physicians themselves.

2. It enlists the services of many groups of laymen, who act under the direction of the doctors.

3. It has the approval of school officials, who contribute substantial sums of public money for the support of the centers.

4. The immunizations are given without propaganda, and with the spontaneous coöperation of local organizations such as exist in every rural community.

Birth-rate in New Jersey

The United States Public Health Reports of July 2, 1937, contain tables of the number of births for every State during the last ten years. The general decrease throughout the greater part of the United States, and New Jersey in particular, has an important bearing on prosperity and progress.

ACTUAL NUMBER OF BIRTHS

One table gives the actual number of births in each State in each of the five years 1932-1936. In 1932, there were 61,219 births in New Jersey; in 1936, there were 53,832. This is a decrease of 12 per cent.

In the same five years, New York showed

a decrease of eight per cent in its number of births, and Pennsylvania, a decrease of 5.4 per cent, while Michigan showed an increase of 3.5 per cent, and Minnesota an increase of 4.5 per cent.

BIRTHS PER 1000 INHABITANTS

Another table of the U. S. Public Health Reports gives the birth rates of each State in each year of the decade, 1927-1936. According to this table, the decrease has been progressive in New Jersey, Pennsylvania, and New York.

The birth rate in Michigan and Minnesota also declined in the years following 1927, and reached their lowest in 1933; but they have shown a substantial increase during the three following years.

DUTY OF PHYSICIANS

What shall physicians of New Jersey do to counteract the decline of the birth rate? One duty about which there can be no dispute is to do everything in their power to promote the health of every pregnant patient, and that of the child. Their activity will be along three lines:

1. Efficient prenatal care.
2. Good obstetrics.
3. Wider practice in child hygiene.

Saving the life of an infant is equivalent to adding one to the birth rate.

Maternal Mortality

The tables on maternal mortality in New Jersey, printed on page 565 of this Journal, should be of intense interest to every practicing physician. Childbirth is causing more deaths than physicians generally realize. No county is free from cases of deaths from this cause; and the disquieting fact is that there seems to be a tendency for their number to increase.

When a new public health movement is instituted, it is taken seriously by a considerable proportion of the people, and there is a reduction in both morbidity and mortality from the diseases against which it is instituted. But there are always a great number of persons who do not hear of the movement, or do not heed it.

Maternal mortality is peculiarly difficult to eradicate, for pregnant women are often told by their grandmothers that swollen legs, headaches, and vomiting, are normal phenomena which they must expect.

To educate pregnant women is a necessity in rural places as well as cities. The responsibility for this education lies primarily with the family doctor. It is unfortunate that a large proportion of people do not have a family doctor, but call a physician only for the acute case of crippling sickness.

The greatest health protection which a family can have is a physician whom they call whenever there is a case of mild sickness. The success of a family physician depends on his clientele of families who call him in preference to any other doctor. Physicians are realizing more and more their responsibilities as the health adviser of all the members of the families whom they call their own. Physicians are showing an increasing readiness to advise pregnant women on their calling list, and to respond to calls from them. A great factor in the prevention of maternal mortality is that of educating prospective mothers to choose a family doctor, and to go to him for advice.

Education of mothers is as necessary as instruction of physicians in obstetrical procedures. The State Department of Health, and the leaders in The Medical Society of New Jersey and of the county medical societies realize the value of education of mothers by public health nurses and welfare workers along two lines:

1. Insist on every needy family choosing a family physician.
2. Insist that the family call the doctor for preventive as well as curative services.

Every family doctor is ready to respond to a call to give advice to any member of a family which is loyal to him as its medical adviser. This is especially true regarding prenatal advice to pregnant women.

Medical Surveys of Counties

An appropriate text for this editorial may be found in Luke 14, 31, in which the "Great Physician" says:

> What king goeth to war against another king sitteth not down first and considereth whether he be able with ten thousand to meet him that cometh against him with twenty thousand? or else, while the other is a great way off, he sendeth an embassage and desireth conditions of peace.

The Publication Committee has approved the project of surveying the medical and allied services which are available in the several counties. The initial survey,—that of Hunterdon County, on page 578,—justifies the expectations of the committee as to the practical value of the project.

The survey is similar to an examination of the resources and liabilities of a bank, in order to determine its strength and its solvency. The members of the county societies have a general idea of medical conditions in their districts, but when they are asked to make a report of their public relations, they are not always able to supply accurate information. The survey is valuable to the local physicians themselves, as well as to the State Society, for it reveals the extent of their organized efforts to provide the people with measures for preventing disease as well as relieving the sick who seek their services.

Hunterdon is a rural county which is singularly free from the influence of great health agencies deriving their powers from outside the county. Its health services and methods are the spontaneous creations of its practicing physicians, and of its local organizations, such as schools, churches, and fraternal societies. The medical needs of the people are, in general, well met, although the methods and results may not have been publicized. The survey is a basis by which the county medical society may evaluate its activities, and plan for their further extension and coördination.

The subjects of investigation and record in the survey are indicated in the following outline:

1. GEOGRAPHIC
   - Location and area
   - Physical conditions
   - Means of travel and transportation
2. POPULATION
   - Density
   - Centers
   - Classification into urban, rural, etc.
   - Occupations and industries
3. PHYSICIANS
   - Number. Population per doctor
   - Distribution,—a spot map of their locations
   - Kind of practice,—general, special, etc.
4. THE COUNTY MEDICAL SOCIETY
   - Number of members;—of non-members
   - Meetings—frequency, attendance, programs, etc.
   - Committees, and the scope of their activities
5. LOCAL MEDICAL SOCIETIES
   - Geographic groups
   - Staff meetings
6. MEDICAL CENTERS
   - Hospitals
   - Clinics
   - Baby Keep-well stations, etc.
7. HEALTH ORGANIZATIONS
   - Health officers
   - Public Health nursing
   - Red Cross
   - Anti-tuberculosis societies
   - Parent-teacher associations, etc.
   - The participation and leadership of the county society
   - The influence of the individual physician in the lay health organizations
   - The attitude of officials,—school, welfare, churches, etc.,—toward the county medical society
8. ECONOMIC
   - The indigent
   - The low-wage group
9. PUBLIC RELATIONS
   - Newspapers
   - Health lectures
   - Radio, etc.
10. HISTORICAL
    - The county medical society
    - Former medical leaders

County medical societies are encouraged to conduct their own surveys, in order to determine their present sources of strength, and the needed extensions of their activities. The resources of The Medical Society of New Jersey are at the disposal of the county societies which are willing to make their own surveys.

The Lag in Applying Public Health Procedures

A favorite argument of the social reformers is that there is a lag of several years between the discovery of new preventive measures and their adoption by physicians; and of still more years before they are accepted by the people generally. The lag is ascribed to the inaction of physicians and the implication is that physicians have the power to speed the application of preventive measures if they would do so.

Every physician who has had a wide experience as health officer knows that the average citizen considers that preventive measures are to be directed against the *other fellow,* rather than himself. He believes that his neighbor's child should be quarantined on suspicion of scarlet fever; but he demands a positive diagnosis of a well-developed disease before he will submit to a quarantine of his own child, or even to a slight degree of restriction of his liberty. Mr. Citizen will even refuse to call a physician lest the sore throat of his child be diagnosed as scarlet fever or diphtheria.

Much education is needed to change human nature. The hardest people with whom the health officer has to deal are those unwilling to impose mild restrictions on themselves for the sake of avoiding possible damage to other people. "Let others look out for themselves" is their motto.

Let those who blame a family doctor for seeming laxity in the diagnosis of measles and similar "children's" diseases remember that restrictive measures are legal procedures which may be tested in court where a suspicion must be proved. If a doctor or health officer cannot swear that a child actually has a contagious disease, he is helpless to enforce restrictive measures.

The public school is an efficient means of enforcing restrictive measures upon mild cases of measles, scarlet fever, and similar diseases. If every school child is subjected to a morning inspection by the school nurse, every departure from his normal behavior is noticed by the teacher or nurse; and if there is a suspicion that the child is coming down with a contagious disease, the child is sent home and is visited later in the day by the nurse or health officer, and the parents are told that the child cannot return to school without a certificate from the family doctor or the health officer. If the parents make a complaint in court, they will have no standing, for the judge will say, "Bring me a certificate that the child is free from contagion, and his freedom will be restored." No doctor will give such a certificate until the case has recovered beyond doubt.

The school system of daily inspection of pupils is an effective method of public health education. It is not theoretical instruction; it is intensely practical and effective, for the school nurse and doctor explain that the exclusion is for the benefit of the suspected child, as well as a protection to other children. The appeal to selfish interest is far more effective than that of altruistic protection to others.

The responsibility for the lag in the application of preventive measures lies with the people fully as much as with the medical profession.

Appreciation of Service

The spirit of the United States Army is that a good soldier shall embrace every opportunity to render spontaneous service above that which may reasonably be expected from him. A secret record is kept of every soldier and officer, and his response to duty; but now and then a public citation is issued calling attention to an outstanding service spontaneously rendered at personal sacrifice and risk.

Response to an opportunity for service is a characteristic of the physician to such a degree that it is expected from him, as it is from a soldier, or policeman, or fireman. However, President Herrman, the Commander-in-Chief of the organized medical forces of New Jersey, has felt constrained to issue a citation in recognition of sacrificing service rendered by a brother physician to a member of his family (page 540).

ORIGINAL ARTICLES

EXPERIENCES WITH THE "HINDENBURG" PATIENTS AND A REVIEW OF CUTANEOUS BURNS

By O. R. Holters, M.D., F.A.C.S.
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Read before the Medical Staff Conference, Point Pleasant Hospital, July 20, 1937.

The disaster to the airship "Hindenburg" on May 6th, 1937, provided us with a number of patients suffering from extensive and serious burns, to justify a report on the management and treatment of such conditions by more recent methods. A brief review of the pathology and chemistry of severe burns is also offered.

The lightning-like spread of the flames in this catastrophe, as related by the surviving radio officer, "was about twenty-seven seconds from the moment of the first explosion until the entire craft was enveloped". The intense heat created by the burning hydrogen would make it appear in retrospect, that it was truly remarkable that anyone on board survived. The toll would have been far greater were it not for the physical properties of hydrogen, being lighter than air, the most intense heat was directed upwards; and this fact too served to prevent more casualties among the ground crew. I inquired of the chief electrician about the inflamability of the fabric, and he replied "that it had been fire-proofed, but could not resist such a heat as was generated".

Those surviving were saved either by jumping, or by being blown from the dirigible by the force of the several explosions.

We had seven of the victims at the Fitkin Hospital, and saw four more in consultation at other hospitals. Of our patients we had a mortality of two, one lived for twelve hours after admission, and the other lived for about three days.

PATHOLOGY AND CHEMISTRY OF BURNS

At this point, it might be well to mention some of the more recent advances made in the pathology and chemistry of burns. I believe that the toxic theory of burns can be accepted to be more nearly the proper explanation for the serious symptoms and high mortality.

We can discard the neurogenic idea, on the basis of the experiments of Markusfeld and Steinhaus,[9] also Katzareff,[8] who demonstrated that the preliminary denervation of a part of a test animal did not influence or safeguard against the toxic effects of burns; but that ligation of the blood supply to that part did prevent the toxemia.

That is not due to injury of the heat-regulating mechanism was demonstrated by Welti,[16] who showed that burned animals died in spite of proper protection against heat dissipation.

Kijanitzin[7] established that toxemia of burns was not due to the retention of excretory products.

Alterations in the composition of blood in burned individuals and animals has proven to be not responsible for the toxemia (Hoppe-Seyler[6]), although blood concentration does exist, and slight changes in the morphology of the red cells does occur. Boyd and Robertsons[13] did find that there was a greater increase of urea nitrogen than of the total non-protein nitrogen, but they explained that this was due to the concentration of the blood.

Edward C. Davidson[5] contributed the important disclosure, in his study of burns, particularly regarding the chloride metabolism, in which it was revealed that there was a lowering of the whole blood and plasma chlorides due to chloride retention in some undetermined form. The practical clinical application of this observation was to assure sufficient salt in the therapy of burns.

To further substantiate the correctness of the toxemia viewpoint, a toxic substance has been isolated by Reiss [12] and others from the urine of burned patients that bears great resemblance, in its chemical characteristics, to pyridine. This substance whose more intimate chemical structure which has not as yet been identified, when injected into animals produces a toxic response, such as observed in burned animals.

By parabiosis between two animals, one being severely burned, and the other normal, the unburned one developed symptoms of toxemia; and if the vascular connection was maintained longer than twelve hours, both animals ultimately died of toxemia. Vogt and Vaccarezza.[16, 15]

Research by Pfeiffer [11] indicated that the cleavage products of protein decomposition obtained from burned skin was found to be neurotoxic, they were soluble in water, alcohol, and glycerine; but insoluble in ether and chloroform.

Further investigation by Robertson and Boyd [13] suggested that the toxic substance was composed of two elements, one thermolabile, nondiffusible, and necrotoxic; the second thermostabile diffusible, and neurotoxic. Experimental evidence by them indicated that the toxic substance or substances circulate in the blood or is absorbed by the red cells. The whole blood contained the toxic factor or factors, while the serum contained relatively much less, because when the latter was injected into animals, it proved poisonous only in enormous doses.

One can readily compare the toxemia arising from serious skin burns as resembling very closely that which is caused by acute intestinal obstruction. While the toxic entity may not be chemically the same, striking parallel symptoms are provoked by the poisonous stimulus.

The pathology resulting from severe burns was first demonstrated by William Cumin (1823),[3] who found a marked hyperaemia of the parenchymatous organs; and when death was delayed several days, a more marked inflammatory change was noted. Another, Bardeen,[2] also observed degenerative changes in the viscera including the bone marrow. A general oedema of all the lymphoid tissues was also found. He compared the latter observation with that encountered in the lymph glands of those who died of acute infections, such as in diphtheria. Weiskotten [18] and Olbrycht [10] described the same pathological changes, but in addition stressed the degeneration of the adrenals.

ERRORS IN TREATMENT

It will be well to mention at this point errors in treatment that serve to complicate and aggravate severe burns.

The use of oils and ointments of various kinds, home and proprietary remedies, in the treatment of second and third degree burns is to be *severely condemned*. The time-honored carron oil therapy, which up to a short time ago was and still is standard equipment on some ambulances and fire apparatus, is the chief offender. In the recent disaster, circumstances were such that those who rendered first aid to the burned victims necessarily used what remedies were readily available at the scene of the accident, which consisted in the main of ointments and oils of various descriptions.

The use of wet dressings of any description during the course of treatment, such as for the purpose of treating allied infection or to soften the eschar, tends to aggravate the toxic symptoms. To quote Edward C. Davidson [4]: "The burns which, while under tannic acid therapy, were dry and clear were converted into sloughing boggy surfaces covered with exudate. It appears that, when the colloids holding the toxic substance were rehydrated, they were again made available for absorption." He goes on to mention in the same article several deaths and obvious aggravations in other cases which occurred because of the wet dressings.

We believe that general anesthetics should not be employed in the initial treatment, because of further depressing the victim's resistance. However, exceptional cases might demand it, but where such an occasion arises, local and field block anesthesia are definitely less depleting to the patient.

THE PROPER TREATMENT

The ideal treatment from any standpoint is that method recently described by Bettman,[1] which is mentioned further on.

Our treatment consists of:

1. Combatting the shock by administering sufficient morphine to allay pain, with due caution not to depress the respiratory rate lower than sixteen per minute.
2. Elevation of foot of bed.
3. Where stimulants were indicated, caffeine sodium benzoate and coramine.
4. Forced fluids by mouth, saline and glucose by vein, and clysis between 3500 and 5000 c.c. per day, depending on the patient's weight, age and general condition.
5. Blood transfusions are given as indications arise, and repeated as often as may be necessary.
6. Careful attention is given to the chloride balance, which can be given by mouth in the form of specially prepared tablets, or as saline parenterally.

First, remove rings from the burned fingers, using wire cutters if necessary.

If oils or ointments have been used, remove them by solvents such as ether, chlorbutanol, benzene or ethyl-acetate.

All blisters are opened, and such fragments of tissue that can be easily detached are debrided, using novocaine anesthesia, if necessary.

Following this, a freshly prepared aqueous solution of 5 per cent tannic acid is sprayed on or applied with swabs to the affected area.

After having thoroughly covered the involved area, a freshly prepared solution of 10 per cent silver nitrate is applied in the same manner. A very practical package is put up by a manufacturer [14] which contains small jars of the tannic acid powders with larger jars filled with distilled water as a solvent. The larger jars are so constructed that a spray which comes with the outfit can be screwed directly on it. This small outfit is so arranged that it can be carried about easily in one's car, and the treatment can be applied at the scene of the accident. Following the silver nitrate, a thin firm coagulum is immediately formed. The burned parts are then placed under a canopy equipped with electric light bulbs, in order to maintain body heat, and to keep the burned areas dry.

For the local treatment of first degree burns, and for first degree alone, any mild antiseptic ointment will suffice.

At the Fitkin Hospital the pharmacist, Mr. Gidlund, has the two preparations always in readiness, weighed out in sterile containers; and when needed, the required amount of distilled water is added and the solutions are ready for use. In a similar manner, one can always have these remedies ready for use in the office.

It is suggested for office use that small amounts of powdered tannic acid, 12.5 grams, be kept in small airtight dark jars, to which 250 c.c. of distilled water may be added at a moment's notice, which will make a 5 per cent solution. The silver nitrate may be kept in readiness in a like manner; 12.5 grams of silver nitrate will make a 10 per cent solution when 125 c.c. of distilled water is added. The retail cost of the tannic acid would be about 15 cents, and the silver nitrate about 40 cents for the quantities specified.

The nursing and surgical care is materially reduced because of the brevity of the initial treatment, and moreover the patient is spared unnecessary suffering required by other longer types of treatment.

The eschar separates anywhere from one to three weeks, the deeper burns taking the longer. If difficulty is experienced in separating the eschar, it should be removed by sharp dissection.

To repeat, at no time should wet dressings be used.

When the coagulum has been shed, and skin grafting is necessary, as it is for the average granulating area, pinch grafting has a higher percentage of takes than other forms of grafting, although plastic procedures must at times be resorted to.

Precaution must also be observed in burns involving joints, that proper methods of splinting are employed to prevent the formation of contractures.

I believe that much missionary work must be done to acquaint the lay public with the evils of applying ointments, oils, and fats to severe burns; and to further impress them that many times such abuses of treatment may be the deciding factor in the life or death of the patient.

1002 Emory Street, Asbury Park, N. J.

DISCUSSION

Dr. Charles Bailey mentioned the use of cortin by Dr. Ivory in the treatment of the burn cases under his care.

Dr. Holters: "I am fully aware of the use of cortin in Dr. Ivory's cases, and I completely recognize that it might be a very valuable adjunct in the treatment of burns, particularly in view of its influence on the chloride metabolism, and also its possible beneficial effect on blood pressure. It would be interesting to hear from other sources regarding their experiences with the use of cortin in the treatment of severe burns."

Dr. George Gaumer, Lakewood: "What emergency remedy would you recommend to the laity in the treatment of severe burns? Would a paste of bicarbonate of soda be safe, and at the same time give some measure of relief to the patient?"

Dr. Holters: "The use of sodium bicarbonate as a wet dressing or as a paste probably would be less objectionable to any other home or proprietary remedy, and certainly preferable to oils and greases. Prior to the tannic acid era, bicarbonate of soda was widely used in the active treatment of burns, on the basis that it prevented autolysis of the burned tissue, because of its alkalinity. From a practical standpoint, I know patients who have obtained considerable relief by its use. I do not believe that it would seriously interfere with the subsequent tannic acide-silver nitrate treatment, as the bicarbonate could be easily removed by gentle lavage with warm water; and then the other treatment can be applied thereafter.

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THE NEUROPSYCHIATRIC CLINIC OF THE GENERAL HOSPITAL

By Theodore Rothman, M.D., Paterson, N. J.
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For many years, the problem of the neuropsychiatric patient has been a subject for much discussion and writing. Because of the inadequate care of this patient by the general medical profession, the State and lay organizations have attempted to correct conditions. With the growth of the mental hygiene movement, clinics grew up like proverbial mushrooms, financed by the State and lay groups. These clinics had a large personnel consisting of psychiatrists, psychologists and social workers. The trend was to take the problems of neuropsychiatry away from the physician, and to turn them over to the grace of the State or related organizations. The neuropsychiatric patient traveled further away from the general hospital and its staff. The general physician aided this migration, thinking that he was serving the best interests of the patient. He did not realize that there were other and better solutions to the problems than state medicine.

The remedy for this trend was, and is, the development of neuropsychiatric clinics adequate to care for the needs of the community in a general hospital. The cost of such a clinic needs no fantastic sums. It should not cost more to run such a clinic than an ordinary medical one. A clinic of this type works for the best interests of the patient, and in many respects is conducive to the best quality of

work. The contact stimulates an exchange of ideas that only aids for the betterment of the patient. The patient prefers the general hospital and its staff as his physician. Referrals to extra-hospital clinics produces a resistance on the patient's attitude. The "stigma" of going to a neuropsychiatric clinic, which unfortunately is felt by most patients, is minimized in a general hospital. Frequently, referrals to a State clinic aggravates a patient's condition. He feels that there is only a small step between a State clinic and a State hospital door.

THE PATERSON GENERAL HOSPITAL CLINIC

The Neuropsychiatric Clinic of the Paterson General Hospital is an illustration of what can be done in organizing a neuropsychiatric clinic in a general hospital, and how it renders the community adequate service with very limited means.

The personnel consists of a neuropsychiatrist, who is the director; two volunteer workers, and a part-time secretary. Working in coöperation with them is the social service department, the departments of physiotherapy, medicine, surgery, gynecology, roentgenology, eye, ear, nose and throat, and clinical pathology. The cases are referred by physicians, social agencies or through the admitting physician.

The clinic works by appointment and meets twice weekly for three-hour sessions. New cases are carefully studied. Wherever necessary, intelligence tests and other laboratory aids are given. If observation is essential, the patient is studied in the medical ward, where the neuropsychiatrist studies the case and has the aid of all the hospital facilities. Children are worked up in coöperation with the pediatric department, which lends the clinic all their facilities. Follow-up is done whenever necessary. The patient is helped to make an adjustment by the coöperation of the superintendent of the hospital, the social service department, the Y. M. C. A., Y. M. H. A., or Y. W. C. A., and the churches and ministers in the community. The volunteer social worker aids in coördinating all these facilities behind the patient.

The type of cases treated in the clinic are organic neurological problems, and certain psychiatric cases. Psychoses, psychopathic personalities, and mental deficients are referred to the State clinic for study and disposition. Only cases that are for custodial purposes are referred. Our organic neurological problems are treated by the department. Brain tumors, and brain tumor suspects are usually referred to the Neurological Institute in New York for neurosurgery. Other neurosurgical problems may also be referred.

METHOD OF APPROACH

An attempt is made to receive the patient at a designated time. No unnecessary waiting is permitted. The initial interview is so staged that rapport between the patient and physician begins at once. Everything is considered treatment in this clinic; therefore from the first moment the patient enters the clinic, every effort is made to help the patient make an adjustment to his disease. The manner of taking a history, the desk registration, the examinations, play as important a rôle in making the patient well, as the specific treatments given. It has been our experience that tactlessness and brusqueness, a frigid efficiency, and a lack of human feeling, may produce an elaborate disease from a simple problem. The naive belief that treatment consist in writing a prescription, only produces limitations in aiding the patient. Rapport between physician and patient is necessary before any efficient planning for the improvement of the patient can be done—sometimes more necessary than a mechanized group of imposing laboratory tests.

The patient is looked upon as a member of society with a disease. Efforts are made to re-place the patient into the social organism which he has been forced to leave. Wherever necessary, we concern ourselves with the patient's economic and social problems. Our volunteer social worker aids in finding the agencies that can perform this task.

No patient is treated as a diseased system. The organism as a whole is considered. The hospital staff aids in treating the case. The foci of infection are removed. Physiotherapy is given in indicated cases. All this is done in

a unified manner, with the neuropsychiatric clinic directing the case.

Every patient is given insight into his problem. An attempt at reëducation is made. The type, degree, and quantity of treatment of this kind is performed in direct proportion to the patient's intelligence. Frequently, suggestion must be our only therapeutic means, because of the type of patients with whom we deal. Only occasionally do we use hypnosis, and then only in cases of conversion hysteria, where immediate palliation of symptoms is necessary. Along with other aids, we always try to reeducate the patient's psyche to greater maturity and adjustibility, whether the problem be organic or psychiatric.

The neuropsychiatric clinic acts as a consultation service for those physicians who have patients who cannot afford a visit to a neuropsychiatrist's office. The physician always receives a report, and is given recommendations for treatment. The neuropsychiatric clinic also maintains a consultation service for the wards, and frequently aids in working up difficult diagnostic problems acting in coöperation with the hospital departments. This mutual coöperation has an educational value for the neuropsychiatrist and for the other departments; the physicians frequently meet and discuss the cases from their own standpoints. Thus a unified approach to the problems of disease is always attempted and separatist specialized manner is disregarded.

There are frequent referrals from the Probation Department of the county, by the schools, by Y. M. C. A., and Y. W. C. A., and charity organizations. Complete coöperation is granted to these agencies. Recommendations are made and treatment given, when necessary.

RESULTS

An analysis of 270 consecutive cases of this clinic was made for three purposes: 1, To measure the efficiency of a neuropsychiatric clinic working with limited financial means in a general hospital; 2, to evaluate the therapeutic results of such a clinic; and 3, to study the type and distribution of cases attending such a clinic.

A case was considered *cured* when the patient had been observed for a period of six months, and been symptom-free for this length of time. A case was considered *improved* when he had been moderately to markedly free of symptoms during the same period. Cases that had had slight benefit, or none, were consid-

AN ANALYSIS OF 270 CASES SEEN IN 1935-1937

	No. Cases	Cured	Improved	Unimproved	Referred	Not Returned
Anterior poliomyelitis	1	1				
Arteriosclerosis of brain and spinal cord	15		1	2	1	11
Brain tumors	3				2	1
Child guidance problems	21	4	5	3	1	8
Chorea	2	1				1
Chronic alcoholism with dementia	1		1			
Chronic subdural hematoma	2			2		
Idiopathic grand and petit mal	29		22		1	6
Developmental anomalies of spinal cord	1				1	
Encephalitis, acute	5	2	1			2
Chronic encephalitis with paralysis agitans	17		10			7
Encephalopathies, birth	5		1	1	1	2
Endocrine dyscrasia	4		1	2	1	
Hemorrhage of brain due to arteriosclerosis	1		1			
Hemorrhage of brain, spontaneous	2	1	1			
Injuries, intracranial	8	3	2		2	1
Injuries to spinal cord	1					1
Menieres disease	1		1			
Mental deficiency	15				11	4
Multiple sclerosis	7		2	3	1	1
Myopathies	4			2		2
Myotonia atrophrica	1					1
Neuralgias	2	1	1			
Neuritis of peripheral nerves	16	5	3		2	6
Psychosis	20	1	1	2	10	6
Psychoneurosis	45	3	16	5	1	20
Raynaud's disease	1		1			
Sub-acute combined sclerosis with pernicious anemia	1		1			
Syphilis of C. N. S.	10	1	4		5	
Tics	2					2
Psychopathic personality	3					3
Encephalopathy, lead	1		1			
Migraine	1					1
No neuropsychiatric disease	22				15	7
Total	270	23	77	22	55	93
Percentages		9	28	8	20	35

PSYCHIATRIC PROBLEMS

	No. Cases	Cured	Improved	Unimproved	Referred	Not Returned
Child guidance	21	4	5	3	1	8
Mental deficiency	15				11	4
Psychosis	20	1	1	2	10	6
Psychoneurosis	45	3	16	5	1	20
Psychopathic personality	3					3
Tics	2					2
Total	106	8	22	10	23	43
Percentages		8	21	9	22	41

ORGANIC NEUROLOGICAL PROBLEMS

	No. Cases	Cured	Improved	Unimproved	Referred	Not Returned
Cases	164	15	55	12	32	50
Percentages		9	34	7	19	31

ered *unimproved*. Referrals were usually made to some other institution where the necessary type of treatment could be given. Unfortunately, of the 270 consecutive cases, ninety-three made only one visit and never returned. This high percentage of cases usually consisted of that ambulatory population who restlessly make a round of visits to as many clinics as are available. The highest percentages of these cases were among, as one would suspect, the psychoneurotics, the arteriosclerotic brain diseases and in child guidance problems. The other patients were very docile and sometimes too stationary.

It will be observed that, considering the referrals and cases that did not return, the results were satisfactory. Only nine per cent of cases that were treated were not improved; while nine per cent were cured, and 28 per cent were improved. It must, however, be remembered that, if our ambulatory "not returned" cases had remained with our clinic, the results probably would have been less cheering.

The cases that responded most favorably to treatment were child guidance problems, idiopathic grand and petit mal, intracranial injuries, neuritis of the peripheral nerves, acute encephalitis, chronic encephalitis with paralysis agitans, and the psychoneuroses. The type of cases that responded poorest were the myopathies, cerebral arteriosclerosis, chronic subdural hematomas, and birth encephalopathies. The cases most frequently referred were psychoses, mental deficiency, syphilis of the central nervous system, and brain tumors.

The most striking results of the entire study are the excellent results obtained in some so-called *hopeless* diseases. The patients with paralysis agitans made excellent adjustments to their disease. Most of the patients had both an objective as well as a subjective improvement. A few, however, were able to resume their previous occupation. Many patients with convulsive seizures made a favorable adjustment, becoming useful beings with an occupation and friends. There were some psychoneurotics treated, who had symptoms for twenty years' standing; but even these, in general, made a favorable adjustment to their disease and became useful members of the community. A small number of mild manic-depressive psychoses were managed through the clinic with a complete remission of the symptoms.

It is also interesting to note that about 85 per cent of our cases were organic neurological problems, while 35 per cent were of psychiatric nature. Contrary to customary belief, the cured and improved cases were much higher in the neurological group than in the psychiatric one. The "not returned" cases were 41 per cent in the psychiatric group, while only 31 per cent did not return in the neurological one. The referred cases were also much larger in the psychiatric group—the referrals being for custodial care. These statistics compare favorably with the treatment of any group of chronic disorders in medicine. In certain respects the advantage lies with the neuropsychiatrist, for in dealing with behavior problems he may be able to so adjust the patient that there is neither recurrence nor any remnant of psychopathology. The old criticism thrust against the neuropsychiatrist that he can only make a diagnosis and has no treatment is an understatement. Such advances in therapeutics as the prostigmin treatment of myasthenia gravis, the quinine treatment of myotonia congenita and atrophica, the vitamin therapy of polyneuritis, the atropine therapy of paralysis agitans, the malarial treatment of dementia paralytica, the insulin therapy of dementia precox, and psychoanalysis, demonstrate that the field of neuropsychiatry is not sterile, but is progressing with inimitable rapidity.

CONCLUSIONS

1. It is suggested that the general hospital attempt to develop a neuropsychiatric clinic of its own, rather than depend on the State or lay organizations for aid. It is shown that it is possible to develop such a clinic with limited financial aid. The best interests of the patient and physician are most adequately served by such a clinic.

2. The neuropsychiatric clinic of the Paterson General Hospital is cited, illustrating an organization that has proved itself practical. Both organic and psychiatric problems are approached with the purpose of replacing the

patient in the social organism, as well as bringing about the necessary changes in the individual organism. Treatment is considered in the broadest sense of the word. Every case is reëducated, and is made to produce a greater maturity and adjustibility of the organism as a whole to its environment. No case is treated as a diseased system; the whole is considered rather than only isolated parts. There is co-ordination between the community, the hospital personnel, and the neuropsychiatric clinic for the treatment of the patient.

3. An analysis of 270 consecutive cases treated at this clinic was made. The results reveal the efficiency of a clinic of this type. It also dispells the delusion held among many physicians that the therapeutic results in neuropsychiatry are poor.

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THE NEW JERSEY STATE PROJECT FOR CEREBRAL PALSY

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Under the direction of the Crippled Children's Commission, a special committee was appointed about a year ago to investigate and draw up a plan for the care and treatment of children suffering from cerebral palsies. This group includes mainly spasticity, athetosis, and pathological motor disturbances present since birth. The committee undertook a two-fold attack on the problem:

First, a State-wide survey to determine the extent and nature of the problem in New Jersey.

Second, the establishment of a special unit for the treatment of a selected group of these children, to demonstrate the possibilities of the method.

The object of this unit is to serve as a guide in the formulation of a more extensive treatment plan. These proposals were accepted and have been put into effect. A staff consisting of a medical director, a psychologist, and a physical therapist has been appointed to carry on the work.

The survey was started with the holding of the first clinic on October 12th, 1936, at the new unit, the Babbitt Hospital, located at the Training School, Vineland, New Jersey. Since then, sixty-five patients have been seen at seven clinics,—four of which were held at Babbitt Hospital, two at the Medical Center, Jersey City, New Jersey, and one at the Hospital and Home for Crippled Children, Newark, New Jersey. A detailed history of each child was taken prior to his being seen by the orthopaedist and psychologist.

A summary of the findings in the group thus far examined follows:

Total boys	48
Total girls	17
Average life age (years)	11.2
Types of Motor Handicap:	
Spastic	20
Athetoid	24
Tremor	9
Rigidity	1
Incoördination and ataxia	2
Spasticity and athetosis	2
Spasticity with cerebral flaccidity	3
Undetermined	3
No motor handicap	1
Etiology:	
Birth injury	49
Congenital defective development	7
Post-encephalitis	4
Post-embolic	1
Undetermined	4
Extent of Handicap:	
Quadriplegia (both arms and both legs)	36
Triplegia (three limbs)	6
Hemiplegia (all of one side)	9
Paraplegia (the lower half of the body)	12
Unreported	1
No motor handicap	1

Speech Involvement:
Sixty per cent of the cases.

Feeblemindedness:
Feeblemindedness was diagnosed in only 25 per cent of the cases.

Prognosis with Treatment:
Eighty-five per cent of the cases seen would receive benefit from treatment.

THE DEMONSTRATION UNIT

The treatment unit, Babbitt Hospital, was opened on December 1st, 1936. As has been stated, the object of this unit is primarily demonstrational, to show the extent to which children of this type can be benefitted by special treatment. To this end, an elaborate system of records and measurements of each child's response are being kept. The complexity of the problem was recognized at the beginning, and a set of standards was established to reduce the number of variables involved. Admission was accordingly limited to boys who conformed to the following conditions:

1. Were between five and fifteen years of age.
2. Had suffered from cerebral palsy from birth.
3. Were ambulatory patients.
4. Were at an average of intelligence, or higher.

Eleven boys have met these requirements and have been admitted to Babbitt Hospital. Ten of these are enrolled at the present time. The average life age is about nine years. Approximately half of the group are spastics, and the other athetoids. The extent of their handicaps were as follows:

Quadriplegia	5	Hemiplegia	1
Triplegia	1	Paraplegia	3

In addition, six of the boys have speech impairment due to muscle defects. The average individual of the group has high average intelligence.

In normal children without physical handicaps, the degree of social independence usually runs parallel to that of the intelligence level; and therefore the social quotient (social independence divided by intelligence level) should be about 100. Thus, those children showing superior degrees of intelligence also show superior social independence when measured by the social maturity scale. In these children, however, in spite of the superior mental level, the average social independence quotient is 56, which is decidedly below the normal; and this condition is directly explained by the limitations produced by their physical handicaps. This gives an indirect measure of the handicap placed on them by the physical defect.

METHODS USED

Upon the admission of a child, an individual program of muscle reëducation is arranged. The methods used for the spastics are quite different from those used for the athetoids; and the individual variations within the group make still more specific directions necessary.

The two chief types of therapy utilized are *systematic relaxation* and *specific muscle reëducation*. The use of these two modalities in various combinations brings about an increased coördination and ability to use the body effectively.

In addition to this, special projects and group activities are developed for the application of the underlying improvement in their daily lives. Also, all the facilities of the Training School at Vineland are available to the group, and are adjusted to meet their specific needs.

A careful check on each child's health is kept by the physician in charge. Illness is promptly cared for by a competent hospital staff. Training in matters of simple self-help is provided. The more formal aspects of the child's education are carried out in the institution's school, which is staffed with teachers especially trained in the teaching of handicapped children. A balanced curriculum of academic and manual subjects is presented on an individual basis. A constructive recreation schedule made of passive and active forms of recreation common to children of their ages fills their leisure time. Emphasis is placed on forms of recreation that have a high therapeutic value for the participants.

RESULTS OF SIX MONTHS' TREATMENT

Six months of the above program have brought gratifying results. Definite improvement is observable in every child under treatment. This is demonstrated not only in the treatment room where progress can be shown in improved relaxation, better coördination of various muscle groups, reduction or elimination of extraneous movements induced by tremor, overflow, and athetosis, and the in-

creased strength of weak muscles. It is also evident in the every day functioning of the children along lines which are of a type largely dependent on muscle action. A detailed statement of improvements noted in the gait of the children with brief comment on other activities is offered as evidence of this.

The results of treatment at the end of the first six months' period are definitely gratifying. The results are here considered in three fields: First, use of legs and walking; second, speech; and third, the use of arms.

USE OF LEGS AND WALKING

On their admission to the hospital the gait of all ten boys was affected to some extent by their physical handicaps. In four cases the children became able to walk without support or mechanical aid. However, their gait continued awkward, uncertain and laborious, resulting in frequent falls, and early fatigue. Three others became able to get from one place to another with mechanical aid,—two using crutches, and the other wearing braces. In each instance they were unable to overcome simple walking hazards, such as going up stairs, without assistance.

Three boys were unable to walk at all. One of these had difficulty with such preliminaries to walking as holding his head and back erect even for brief periods. He, as well as one of the boys who uses crutches, could not stand alone, even momentarily. The other two boys who did not walk could stand alone but could not take more than two or three steps without losing their balance.

At present the walking, or attempts at walking, of every child has improved. The two boys most recently admitted are not being included in the following résumé, owing to the briefness of their treatment. There is now only one of the remaining eight children who does not walk alone. He has gone a long way in mastering the preliminaries to walking. He is daily developing better muscular coördination as indicated by improved foot placement while walking supported, and is developing more strength in his neck and back muscles. One of his most encouraging accomplishments is his standing alone for almost two minutes at a time. The two children who could stand alone but could not walk are now walking. One of these boys has taken 425 steps without aid, while the other has progressed more rapidly and remains on his feet for comparatively long periods. Both of these boys are using their walking ability for practical purposes.

The two boys who could get about with mechanical aid have improved. The boy who wore braces has, since January 19th, 1937, been getting along without them. At first, he could walk for only very short distances without the aid of walls, rails, or objects to steady him. At present, however, he walks about the house, only now and then reaching out for support.

The other boy,—the one who depended on crutches,—continues to require his crutches, but has improved in that he is now able to stand alone for almost two minutes and can walk for short distances with the aid of one crutch or one hand support, and is developing a better technic through the use of hand tripod crutches.

The three children who were able to walk without support upon admission are all walking better. One has demonstrated the following improvements: Improved foot placement, heels down and feet parallel, knees held straight, formerly greatly hyperextended, erect head position showing increased neck strength, and finally less foot drag in walking.

Another boy is now able to walk "perfectly" under supervision. Athetoid and overflow movements have been greatly reduced, feet are now placed heel first and parallel while formerly toes touched first and were turned inward, elbows and wrists remain relaxed while walking.

The other boy, the one who was least handicapped in walking, has improved in that he is now able to walk by placing his heels on the floor, and with his feet toeing out slightly. Formerly he walked with his feet turned in, and was unable to put his heels down.

SPEECH

The speech mechanism is a part of the muscular handicap in six of the ten children. The speech of two of these was difficult to understand for one who was not accustomed to this

type of speech defect. The speech of the three other children was not understandable save for a few words, except for those who were closely associated with the child, and even then difficulty was encountered. Improvement in speech is evident in all cases.

Drooling was present in five of the ten children. Two of them drooled almost continuously, necessitating the use of bibs. The bibs are no longer necessary, and the other children show improved control of their saliva.

USE OF ARMS

Upon admission, five of the children were unable to feed themselves because of inadequate muscle coördination. Today all of the children can feed themselves. There are two that require some assistance when eating semisolid foods.

At the beginning, only three of the children could undress. The failure of the others was attributable to their physical handicaps. Now all of the children can remove their clothing if unbuttoned, and five of them can unbutton.

At first there was not one boy who could completely dress himself. Since that time there is one boy who has learned to dress himself completely, including tying his necktie. Two others can dress with the exception of tying their ties. Five others can put their clothes on, and are in process of learning to button. Two can put on leg and arm garments, but are unable to manage those of a type that slip over the head. These accomplishments show excellent improvement in large-muscle coördination, and some gains in finer coördination.

PROGNOSIS

There are no means of predicting exactly the extent to which these children can be benefitted ultimately. The records of their progress will aid in determining the prognosis of other children like them who will be treated. To date, these boys have responded to the treatment better than was anticipated. They are responding now, and there is every reason to believe that they will continue to improve.

The State survey is furnishing data that has never before been collected in a large quantity, and should provide valuable information on the problem in time. Those who know and have seen the work are enthusiastic about it. The New Jersey Crippled Children's Commission has received a great many requests for assistance from parents of out-of-State children. Two states, Maryland and North Carolina, are planning similar programs that are to be fashioned after the New Jersey plan.

FALLACIOUS BELIEFS REGARDING BLOOD TRANSFUSIONS

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Read before the Clinical Society of the North Hudson Hospital, December 8, 1936.

Among the measures most effective in reviving the exhausted and exsanguinated patient, namely,—rest, heat, elevation of the body proper above the level of the heart and brain, the introduction of saline and glucose solutions, and the transfusion of human blood,—the latter is by far the most dramatic in its effect. Moreover, no other therapeutic measure has been credited with as wide a scope of virtues and efficacies.

Great steps forward have occurred in the development of our knowledge of this measure since the clinical application of the isoagglutinin phenomenon in 1910. Soon thereafter military surgeons had fertile opportunity to rediscover its usefulness, and the two decades which followed saw rich advances in the understanding and prevention of the complications and sequellae of blood transfusions. Today, the operation is recognized as "one of the most successful therapeutic practices in medicine".[1] This conviction is given foundation by such records as those of Beck,[2,3] who reported 950 transfusions without any accidents; Schiff,[4]

whose total of 6000 transfusions performed in Berlin and London were complicated by but four accidents and one fatality; Tiber,[5] in New York, who reported 1400 transfusions with two fatalities.

Yet, in spite of this comparatively wide range of safety, there are practitioners who offer one or another of the following alleged "dangers" to blood transfusion, which it is our purpose to disprove:

I. A blood transfusion of substantial volume overloads the circulation.

II. Transfusion of blood causes a rise in blood pressure, undesirable because in the bleeding patient it will defeat the capacity for clot formation or dislodge the clot forming or already formed.

III. Air introduced during the transfusion of blood courts the danger of air embolism.

To disprove these alleged "dangers", the authors offer the opinions of physiological authorities, and the evidence of certain investigation; the experience from approximately 500 transfusions performed by one of us substantiates our contentions.

I. As regards the belief that a blood transfusion of substantial volume overloads the circulation, a review of the fundamentals on the physiology of blood volume is held pertinent: Wright[6] says that "the blood volume is kept very constant in the normal person, and it is difficult experimentally to produce any material or lasting alteration in this volume". Obviously, there must be a regulating mechanism functioning to maintain this constancy both in health and disease, and its physiology concerns changes in capillary blood pressure and osmotic pressure of plasma proteins. The functioning of this mechanism is clarified as follows:[6]

"If saline is injected intravenously into a normal animal, the excess fluid is accommodated on the venous side of the vascular system, with a consequent rise of venous and capillary pressure. The excess fluid also dilutes the plasma proteins and lowers the osmotic pressure. For these two reasons, i. e.:

"1. The rise in filtering force in the capillaries, and

"2. The lowering of the antagonistic protein osmotic pressure.

"Fluid escapes rapidly from the vascular system into the tissue spaces" * * * thus * * * "The tissue spaces serve as reservoirs into which fluid can be passed when there is excess in the blood and from which fluid can be called upon when the blood volume is decreased."

Applying this truth to the effect of blood transfusion, Wright[6] says:

"If blood is transfused into a normal animal, there is an immediate rise in the hemoglobin concentration of the blood of the recipient, and in a few hours, the blood volume is restored. This involves an ejection not only of the added plasma, but also of a volume of the animal's own plasma equal to the bulk of the injected red corpuscles. * * * Later, the excess of red blood corpuscles is disposed of by a process of hemolysis."

Boycott and Oakley[7] offered experimental evidence for this contention by noting:

"The increase of blood volume produced by transfusion is, in normal animals (rabbits), soon corrected by the expulsion from the blood of the injected plasma and enough of the recipient's own plasma to make room for the injected corpuscles."

It cannot be denied, however, that voluminous vein infusion has recognized contraindications, and Fauntus[8] mentions dropsy, pulmonary edema, and marked cardiac insufficiency. He advises that "whenever one is doubtful of the integrity of the myocardium, the quantity of fluid infused must be limited so as to avoid overloading the right heart". Yet, even this alleged "danger" is refuted by the work of Meek and Eyster,[9] who gave intravenous injections of whole blood to normal dogs in quantities varying from 25 to 103 per cent of the total volume without permanent increase in the diastolic size of the heart. An additional truth was observed in the finding that capillaries and venules acted as reservoirs for the storage of excess fluid. Bock,[10] discussing this subject, concludes that "there is little ground for the belief that the circulation will be embarrassed by transfusion at a time when the total circulating volume is decreased" (from hemorrhage).

II. Beckman,[11] on the treatment of hemorrhage in peptic ulcer, says there are two schools of thought in regard to the advisability of immediate blood transfusions both for increasing the clotting power of the blood and filling out the vessels. "Perhaps most physicians fear the injection of more than 150 to 200 cc. for

fear the induced rise in blood pressure will blow out the clots." [11] To dispel this argument requires but one more support from our knowledge of the physiology involved. It is known that "the constancy of the blood pressure is attained mainly reflexly by the aortic and sinus nerves, principally by means of the variable tonic inhibitor influence which they exert on the cardiac and vasomotor centers (and on adrenalin secretion). Through this mechanism a rise of blood pressure at rest increases their inhibitor activity, a fall of blood pressure lessens it.[6] Consequently, in severe hemorrhage, the immediate fall in blood pressure is at once combatted by a reflex acceleration. Conversely, then, when blood is introduced into the circulation by transfusion, the momentary rise in pressure sets this mechanism into operation, the inhibitor activity is increased and cardiac output kept constant. Thus, we appreciate that replenished volume and momentary rise in blood pressure will not interfere with the capacity of the blood to clot or jeopardize the clot already formed.

That the transfusion of blood even in voluminous quantities has scientific rational is further borne out by Reschke,[12] who recommends, in the face of extreme anemia from an exsanguinating hemorrhage of ulcer origin, a preoperative massive transfusion of 1000 to 1500 cc. of blood (from two or three donors) in addition to about the same amount of dextrose solution.

III. The fallacy that the accidental introduction of air in blood transfusions is frought with great danger to the patient, arises from myth and false reasoning. Although the danger of air embolism is recognized, the list of prominent causes includes vein infusion, and blood transfusion as an extreme rarity. Air embolism has been reported following wounds of the neck, thyroidectomy, irrigation of the maxillary sinuses, manipulation of the intracranial venous sinuses, fractures affecting long bones, manipulation of the pregnant and puerperal uterus, filling of the urinary bladder, injection of air into the urethra and peritoneum, crushing injuries to the thorax, and the operation of pneumothorax.

A search of the literature for the past ten years revealed but one case of fatal embolism following intravenous injection at the elbow.[13] Ingleby,[14] in her classic review of the causes of sudden death, indicates the possibility of air embolism following injury to a large vein but makes no mention of such an accident in connection with the transfusion of blood. Nordland [15] and his co-workers observed that as much as 30 cc. of air could be injected rapidly in dogs without any ill-effects. Although the fatal amount for humans has never been determined, one of us has repeatedly observed the injection of small amounts of air during intravenous infusion and transfusion to be harmless. Also on two occasions in the course of blood transfusions of average volumes, we made note of the introduction of as much as 30 cc. of air without the slightest suggestion of distress. We recognize that air entering a pulmonary vein may be carried directly to the brain, causing sudden death—as has occurred in crushing injuries of the thorax, but air entering a systemic (median Basilic) vein in the course of a blood transfusion is arrested in the lungs. It may be concluded that no clinical manifestations should be anticipated from the amount of air which may be accidentally introduced during a carefully managed transfusion.

CONCLUSION

1. The operation of blood transfusion is a remarkably safe procedure today.

2. Numerous practitioners hesitate to employ blood transfusion because of certain misconceptions and fallacies.

3. Blood transfusion of substantial volume (500-1000 cc.) does not overload the circulation because excess volume is accommodated in peripheral reservoirs, namely tissue spaces, capillaries and venules; the filtering force in the capillaries and protein osmosis are the mechanisms involved.

4. The fallacious belief that blood transfusion and resulting blood pressure rise jeopardises the clot or interferes with blood coagulation in the bleeding patient is disproved from a knowledge of the physiology involved; this concerns the reflex influence of increased

venous return on sympathetic and parasympathetic nerves.

5. There is extremely little danger of fatal air embolism during blood transfusion because of the point of entrances as well as the negligible amount of air commonly introduced.

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A CASE OF TORSION OF THE FALLOPIAN TUBE SIMULATING ACUTE APPENDICITIS

By Daniel R. Mishell, M.D., Newark, N. J.

Read before the Staff of St. Mary's Hospital, Orange, N. J., October 13, 1936.

Infarction of the fallopian tube, with the production of extreme hyperemia and subsequent devitalization of the tubal structure, has not often been reported. A review of the recent literature reveals a few reports which indicate that torsion is the most common cause.

W. Nash [1] reported a case history of torsion in a previously diseased tube simulating appendicitis. J. Casagrande [2] discussed an uncomplicated case of torsion of the fallopian tube with resultant haematosalpinx and mentioned twelve cases reported in the literature, stressing the mechanism of torsion. E. Shute,[3] in his article on adnexal torsion, noted the simulation of symptoms to those occurring in acute appendicitis and ectopic pregnancy and concluded the pain was not due to the torsion per se, but rather to a hemorrhage into the muscle wall especially under the serosa. J. Regad [4] states that although torsion may occur in a healthy tube due to a disturbance in peristalsis, it is more often found in tubes which have been diseased. He also describes the effect of torsion upon adjacent organs and points out that spontaneous amputation of the adnexae may occur.

The following case is reported because of the rarity of the condition and also because it exemplifies the difficulties in making a differential diagnosis when encountered in practice.

Mrs. K., aged thirty, was first seen on the evening of May 3rd, 1936. Her chief complaint was abdominal pain accompanied by vomiting—duration eight hours. She had been married for seven years, had one child five years of age, and had no miscarriages. Her menses began at the age of thirteen, were regular every 26-28 days; duration 4-5 days. Her previous period occurred April 8th and was normal in character. Two days prior to her present illness she began to menstruate and continued to do so up to the present time. She had no previous operations, severe illnesses or other attacks of abdominal pain or distress.

On the afternoon of May 3rd she was suddenly seized with severe abdominal pain which started in the epigastrium and became localized in the right lower quadrant where it remained, increasing in intensity.

Physical examination revealed the patient to be a well-developed and nourished female who did not appear to be acutely ill. Abdominal examination revealed an area in the right lower quadrant which was tender to deep and superficial pressure. There was moderate rigidity of right lower rectus muscle but no rebound tenderness. No masses were palpable, and there were no signs of fluid in the abdominal cavity. Vaginal examination was not made as the patient was menstruating. Rectal examination showed the uterus to be normal in size and position; no masses were felt in either fornix, but palpation of the right side elicited tenderness and muscle spasm.

The patient was sent to the hospital for further study. A blood count was taken which showed 9400 white blood corpuscles, 75 per cent polymor-

phonuclears and 25 per cent lymphocytes. The urinalysis was essentially negative. The rectal temperature was 100° F.

The following morning, after a period of observation during which the symptoms did not abate, the patient was prepared for laparotomy, the preoperative diagnosis being *acute appendicitis*. A right rectus incision was made, and upon opening the abdomen the appendix was found to be retroceal in position and appeared to be normal upon gross examination. No free fluid was found in the abdomen. The coils of the adjacent ileum were moderately distended.

In view of the negative appendiceal findings, the incision was lengthened and the pelvis explored. A rather unusual picture presented itself. A coil of ileum was sharply angulated in the right pelvis producing a partial intestinal obstruction. The angulation was produced by a fibrinous band of adhesions which was attached to a black object, the identity of which was obscured by the overlying gut.

After the adhesions were separated, thereby relieving the obstruction, the underlying dark mass was found to be the outer two-thirds of the right fallopian tube. There was a sharp line of demarcation between the ampulla and isthmus. The ampulla and fimbriated end of the tube were completely engorged, giving an appearance of a solid mold of black wax. The engorgement involved the mesosalpinx and the upper part of the broad ligament.

The right ovary was normal in appearance. No corpus luteum of pregnancy was observed. The rest of the genital tract appeared to be normal. After ascertaining that the intestine was perfectly viable, a right salpingectomy and appendectomy were performed, and the wound was closed without drainage. The patient made an uneventful recovery and left the hospital on the tenth day.

The pathological report, rendered by Dr. Edward Fendrick, was "Hemorrhagic infarction of the right fallopian tube probably secondary to torsion. The external surface of the tube is black, hemorrhagic, and necrotic in appearance. On section, the entire wall is edematous and hemorrhagic. Microscopic examination shows the muscular layer of the tube to be densely infiltrated with blood. The blood vessels are thin-walled, and dilated, and contain thrombotic masses of blood clot. The lumen and mucosa are normal in appearance, there being no evidence of previous disease or chorionic villae."

Comment: This case was presented, first, because of its rarity; and second, to emphasize the necessity for a thorough intraäbdominal examination in those cases which come to operation with the pre-operative diagnosis of acute appendicitis and in which no gross pathology of the appendix is apparent. According to other cases reported in the literature, mechanical torsion of a healthy tube can occur, thereby cutting off the blood supply and thus causing an intense engorgement with subsequent devitalization of tissue, often to the extent of spontaneous amputation. Torsion of a healthy tube probably occurred in this case, producing a haematosalpinx, followed by fibrinous attachment of the ileum and partial intestinal obstruction.

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EVIDENCES OF EARLY INFECTION IN TUBERCULOSIS

By IRVING L. APPLEBAUM, M.D., Newark, N. J.

From the Babies' Hospital. Read before the New Jersey Tuberculosis League on October 23, 1936, at Newark, N. J.

In a discussion of early infection of the childhood type of tuberculosis, it is well, first of all, to define what is meant. The earliest type of case, of course, is the *tuberculin positive* child, in whom no anatomical lesion can be demonstrated—neither by complete clinical examination nor by roentgenographical studies. This child is classified as an observation case, and our only evidence of infection lies in the skin sensitivity tests. Detection usually occurs through the medium of a tuberculosis health program, and less often because of a routine procedure in some hospital, clinic, or private office of a physician. This is the type of case in which detection is preferable, because here it is earliest.

However, there are early cases to which the term *disease* is applied rather than *infection*, because there is gross evidence of tuberculous invasion. The pathology resides chiefly in the

lymphoglandular system; and among the organs in the body affected, it is especially found in the glands of the pulmonary system. Therefore, for practical purposes we may view this as a respiratory affair, because it involves the glands in the mediastinum draining the lungs, in the structure of which the initial or primary lesion occurs. The center of infection in the lungs is often not seen on the celluloid film; and even when it is seen, the enlarged glands, as a rule, predominate the picture.

CASE-FINDING

Now, how may we search for this early type of case from a clinical point of view. At the Babies' Hospital in Newark, New Jersey, we have a children's lung clinic, to which many cases are referred for diagnosis. All the routine procedures are employed, and our findings bear out the following salient facts:

1. The *history of the case* sometimes reveals an exposure to infection; and the diligence of the interrogator is an essential factor in producing suggestive leads. The familial history may or may not be enlightening and is often negative. However, a contact may even be found outside of the immediate family, and guilt can sometimes be established among grandparents, aunts, uncles, servants, and frequent friendly visitors. Unfortunately this link is often difficult to uncover in the early cases.

2. *Symptoms* in the infant or child are often misleading. A complete absence of subjective findings is not uncommon. Fatiguability out of the ordinary for the particular individual, and a slight daily rise in temperature, rank foremost. Cough, expectoration, chest pain, and loss of weight are rarely found, and are usually complaints of the more advanced cases when the lung is more structurally involved.

3. *A paucity of physical findings* is another outstanding observation. Even after checking with x-rays, it has been our experience to be unable to localize pathology by physical means. The stethoscope is far from being potent. As for D'Espine's sign (bronchial breathing over the upper dorsal vertebrae), employed particularly by the French school where it originated, no value can be placed on it, and in our opinion it can be definitely discarded.

TESTS WITH TUBERCULIN AND X-RAYS

We are compelled to resort to the *tuberculin test* and the *x-ray studies* of the positive reactors. In the final analysis, our evidence rests chiefly with these two procedures. They comprise our real machinery of detection.

The ultimate purpose of a tuberculosis case-finding plan is to discover the disease in order that the patient may be saved from invalidism and death, and that he may be prevented from passing the infection to others. With this as our basic concept, the measure of practical effectiveness can be expressed in terms of early cases discovered.

In the *individual* study in hospital or private practice, it is some one or more clinical findings previously discussed which may suggest the application of the skin test or x-ray. If the clinical finding is absent, as it sometimes is, the early case is missed.

In a *group* study, the practical thing to do is to perform a tuberculin test on every individual, and to x-ray the reactors. By this plan, no early case is missed.

In conclusion, one cannot help but comment upon and discourage apathy. It is not a question of playing a waiting or passive game. We must be aggressive to eradicate this scourge, and our only hope lies in pursuing a militant course—a *tuberculosis health program* and group study of children for every community.

HOW THE RADIOLOGIST CAN HELP THE GENERAL PRACTITIONER IN GASTRO-INTESTINAL DISEASES

By George E. Pfahler, M.D., Sc. D., Philadelphia, Pa.

Read before the Pierson Medical Society, East Orange, N. J., April 21, 1936.

The general practitioner is, and should be, the most important factor in the diagnosis and treatment of any disease. This applies particularly to the diagnosis and treatment of diseases of the gastro-intestinal tract. It is well known by all of you that many of the gastro-intestinal symptoms are secondary to some other condition in the body, such as some mental disturbance, some hereditary imbalance, or more commonly a reflex condition secondary to disease in another organ. Therefore, it is self-evident that the family physician who is familiar with the habits and the previous illness of the patient and the family is in a position to evaluate symptoms better than any specialist. It is also self-evident that the great majority of gastro-intestinal diseases can be, and should be, handled entirely by the general practitioner.

On the other hand, there is probably no gastro-intestinal symptoms or disease in which the radiologist can not be of some help, either in furnishing negative or positive evidence in the diagnosis. If nothing abnormal is found by an x-ray examination, it is more evident that the symptoms are due to some reflex focus or neurotic disturbance, and such examinations, however, should not be depended upon unnecessarily, for they do involve expense to someone even if the patient does not pay. There are, however, symptoms and diseases of the gastro-intestinal tract which absolutely demand a gastro-intestinal study by a competent radiologist in order to determine the diagnosis, for we all know that the early symptoms of cancer, for example, may simulate a number of other conditions, and if these symptoms are allowed to continue more than a few weeks with an uncertain diagnosis, valuable time may be lost and the disease may have passed beyond control.

I must emphasize the point, however, that some cases of cancer of the gastro-intestinal tract show far advanced disease before any symptoms have been recognized or complained of by the patient. At the present time, we do not know how long a cancer of the gastro-intestinal tract may be developing before it produces definitely localizing symptoms.

CASE REPORT

A friend of mine called upon me for an x-ray examination because he had diarrhea. In the course of the studies, I found in the stomach the appearances of carcinoma. He was, however, entirely free from symptoms referable to the stomach. He was well nourished, he ate his meals regularly and complained of no indigestion. His diarrhea was only a temporary matter. I obtained the judgment of four or five of my American colleagues whom I considered the most capable of expressing an opinion on the films. They were exactly in my position of believing that it was carcinoma, but hesitated in saying so in the absence of any symptoms. The patient, who was a physician, refused any further examinations until seven years later, when he had developed gastric symptoms; and then he was re-examined and an advanced inoperable carcinoma was found. He died within a year thereafter.

This case illustrates how cautious we must be; and when abnormal conditions are found, it is the duty of the patient and the physician to not be satisfied until a definite diagnosis has been made, and proper treatment instituted. Most delays, however, are due to a lack of thought of serious diseases such as carcinoma, and therefore, a review of some of the conditions that we should think of in connection with gastro-intestinal symptoms may be helpful.

ESOPHAGUS

Difficult or painful swallowing is a symptom that should never be neglected. It must be remembered that we generally are not conscious of the act of swallowing or of the food passing from the pharynx to the stomach; therefore, if that act becomes a conscious one, there is something abnormal. If the pain or soreness involves the upper part of the esophagus, a careful examination of the tonsils, pharynx, and larynx should be made. In this region, it must not be forgotten that a short-

exposure lateral film will give a great deal of information regarding the pyriform sinus and the larynx.

Sensations connected with swallowing at a point below the level of the larynx are usually due to some kind of constriction, either from pressure externally or from contracture of the esophagus itself. Constrictions within the esophagus may of course be due to scars from previous ulcerations, whether following traumatism, infection, chemical irritants, or simple ulceration; but most commonly, we must think of carcinoma. When a constriction is present, with no history of previous esophageal trouble, we must consider carcinoma until this has been eliminated. Carcinoma may occur anywhere along the esophagus.

The treatment of carcinoma of the esophagus, however, has not been a brilliant success by any known means. Some hope has been developed from the use of carefully directed high voltage x-ray treatment; and a few cases seem to have gotten well. Some have gotten well locally, and still the patient has died of metastasis elsewhere. However, much progress is being made in roentgen therapy; therefore, we are hoping to accomplish results even in carcinoma of the esophagus that have not been accomplished before.

STOMACH

The stomach is a very responsive organ and may give rise to local symptoms due to many causes. Its reflex symptoms are more commonly associated with the gall-bladder, the appendix, and the uterine organs than any others; and, therefore, if one makes a radiological study of the stomach and finds nothing abnormal in the stomach or duodenum, then a careful search of the gall-bladder, appendix, and the pelvic organs is absolutely essential.

When all of these organs are found normal, toxic or neurogenic disturbances must be considered. A *gastric ulcer* is recognized radiologically by the evidence of some disturbances in the rugae, by spasm of the circular muscles, by a niche, or by the "bar" symptoms described by Franckel, or by the evidence of a secondary gastric dilatation. The niche is most commonly located along the lesser curvature, but the evidence of a penetrating ulcer may be found anywhere. A disturbance in the rugae is most commonly shown in an ulcer involving the anterior or posterior wall. The "bar" symptom is produced by a rigidity of a small portion of the abdominal wall which interferes with peristalsis, and, therefore, remains rigid and fixed, as is shown in multiple films; or which can be shown when a series of peristaltic waves are recorded by multiple exposures on a single film. Ulcers of the stomach may really involve the pylorus itself. It is likely that pyloric obstruction and secondary dilatation comes from this cause. These ulcers then lead to thickening, which produces an appearance strongly suggesting carcinoma, but if one is careful with the history and careful in studying this constriction from various angles, the niche of the ulcer can be commonly shown. Usually a benign ulcer can be differentiated from a malignant ulcer, but not always. At times, the ulcer itself may be relatively small, but may produce a thickening or enlarged border surrounding the ulcer which gives a defect large enough to be looked upon as a carcinoma. McCarthy says that an ulcer larger than a quarter is malignant.

Carcinoma of the stomach unfortunately is usually far advanced when the patient comes for an x-ray examination. That fact must indicate that the symptoms of carcinoma are very indefinite. If it were not for the expense involved, certainly we would be justified in recommending an x-ray study of the stomach and bowels twice a year after the age of thirty-five. As a matter of fact, I have been carrying that out on myself for many years.

The special characteristics which distinguish carcinoma of the stomach are its rigidity, its uniform deformity which permits one to superimpose a series of films if made in the same general position, and the defect is always at the same point. The irregular serrated borders are characteristic of carcinoma. We no longer expect dilatation of the stomach or obstruction, such as was taught as the symptoms of carcinoma when I was a student. Carcinoma of the stomach, when diagnosed, should be operated upon if at all possible. If operation

can not be performed, then the patient should receive high voltage x-ray treatment. A few of these cases will respond.

At present, it is the opinion that the larger and more bulky carcinomas of the stomach are more or less responsive to irradiation, while the scirrhous carcinomas are not responsive. Therefore, when one can make such differentiation in the type of tumor present, one can form some ideas to the possibility of getting some benefit from irradiation.

It is my opinion that no carcinoma of the stomach should be overlooked today by the radiologist when examined thoroughly with modern technic. On the other hand, one can not always determine whether a lesion is a benign ulcer or is carcinoma. Such lesions that are doubtful in diagnosis are usually early lesions, and therefore, belong generally to the operable type. It would seem advisable in any such doubtful case whether one is dealing with carcinoma or ulcer, the patient should receive the benefit of the doubt, and have an exploratory operation with plans made for resection.

With regard to gastric ulcer, two factors should be borne in mind; first, that an ulcer may be present and be of short duration. I believe that it is possible for an ulcer to be present and to heal within three or four weeks. Such ulcers, however, very commonly recur; and, therefore, a single negative examination for ulcer with persistent symptoms should not be conclusive evidence against the presence of an ulcer, and the examination should be repeated. A relatively new fact concerning ulcer is connected with the treatment. In 1934, Nemenow reported on 360 patients suffering from gastric and duodenal ulcer with recovery of about 60 per cent from x-ray treatment given over the ulcer, or over the sympathetic ganglia in the dorso-lumbar region. This, at first thought, seems to be more or less ridiculous; but when one considers that sympathectomy has been done for the same purpose and with success, the idea is not so far fetched; and since the treatment is not an extensive one, and relatively harmless, it would seem worth while considering, providing the case is kept under observation by means of the x-rays so that one can determine whether the ulcer is healing or not. In any non-operative treatment, the progress should be determined by subsequent x-ray examinations at intervals.

DUODENUM

In the consideration of the duodenum, one must not think simply of duodenal ulcer. Duodenal ulcer can probably be recognized in about 95 per cent of the cases, and perhaps even more than that if the study is very thoroughly made. The duodenal ulcer is recognized by a defect in the outline of the bulbous duodenum, or by a niche or penetrating effect. In order to demonstrate such defects, one must examine the patient in all positions, standing, supine, prone, and oblique. Such complete studies unfortunately require a number of films, and generally speaking, the fluoroscopic examination alone is not reliable. In addition to the duodenal ulcer, we must consider duodenitis, which is recognizable by the irritability of the duodenum which makes it non-retentive; or in the chronic form, shows a deformity of the duodenum. In this connection, the duodenitis must not be considered as referring simply to the first portion of the duodenum, but the second portion of the duodenum may also show this disease. Duodenal diverticulae may be present, and may give rise to symptoms. On the other hand, such a lesion may be present for years and give rise to practically no symptoms. Duodenal polyps or redundant mucous membrane in the neighborhood of the pylorus are at times the cause of obscure symptoms. They cause smoothly outlined filling defects, but should always be demonstrated in a number of films in order to arrive at a positive conclusion.

GALL-BLADDER

Disease of the gall-bladder and associated disease of the biliary tract is a very common cause of gastro-intestinal symptoms. According to my experience, the great majority of cases of gall-bladder disease do not have the typical biliary colic; but the symptoms are vague and more often consist of discomfort, gas, abdominal distention, or vague pains in the gall-bladder region or elsewhere in the gastro-intestinal tract. The gall-bladder symptoms, as has been so well described by Vin-

cent Lyon, represent a group of vague symptoms and usually a rather prolonged history. In this, heredity, internal secretions, and infection play a part, and the history as obtained by the general practitioner forms a very important factor in the diagnosis. However, no study of the gall-bladder is complete without any x-ray examination. In this x-ray examination, it is desirable in my opinion to first of all examine the upper abdomen to determine the size, outline, and position of the liver, and to make at least one or two films of the gall-bladder preliminary to the administration of the gall-bladder dye.

By means of the dye study, one can then determine the function of the gall-bladder as to whether it fills, concentrates, contracts, and empties normally. One determines the position of the gall-bladder, and if shadows have been previously found suggesting gall-stones, one can show definitely whether these shadows correspond to the gall-bladder or not. We believe that it is very important to study the gall-bladder at frequent intervals during the emptying process, because at times, non-opaque gallstones are shown during the contracture of the gall-bladder as it empties that would otherwise not be shown at all. In this connection, we must not forget that a gall-bladder may function practically normally and yet contain gallstones. That is also self-evident by the fact that a patient with gall-bladder stones commonly has illness at intervals, and it is likely that during the intervals between illnesses, the gall-bladder is functioning perhaps normally, and therefore, no symptoms are produced. On this account, one must not just hastily conclude that the gall-bladder is normal at all times merely because at examination the gall-bladder shows a normal function. The recognition, however, of gallstones either of the opaque, or non-opaque, variety is definite evidence of gall-bladder disease, and should therefore receive appropriate treatment.

COLON

Much colon work has been done in the study of the small intestines by Mills and to a lesser extent by others. The small intestines are responsive to disturbances in the stomach or the colon. One can record sacculations, adhesions, and especially diverticulae. I will take the opportunity to demonstrate to you a number of cases of Meckel's diverticulum which may give very serious symptoms, and also may be undiagnosed for some time. The study of the small intestines must be made usually between the second and sixth hour after giving an opaque meal.

In the study of the colon, our most valuable service has been rendered in the diagnosis of carcinoma. No other reliable means is available for such a diagnosis until there is a very definite palpable mass associated with bleeding or obstruction. However, by means of the roentgen rays and an opaque meal or opaque enema, one can recognize a filling defect in the colon, probably as early or earlier than any symptom will be produced; and if one uses the combined opaque enema and the injection of air into the colon, the earliest evidence of carcinoma can probably be found. This requires careful detailed study; and I am sure the best results can not be obtained by merely having a film or several films made by a technician. I regard the fluoroscopic examination as very important. The patient must be rotated in various angles until every part and every portion of the colon is clearly shown. Then when a defect or any abnormality is recognized, multiple films must be made in order to get the most active results.

Even carcinoma of the rectum can be recognized if properly studied. However, the rectum can be very well explored by the proctoscope or by finger. I believe that the great majority of carcinomas of the rectum can be recognized by the examination with the index finger, and it is therefore very important in all gastro-intestinal cases that the family physician should examine the rectum with his finger.

MATERNAL MORTALITY STATISTICS

MATERNAL WELFARE ARTICLE NUMBER NINETEEN

By Arthur W. Bingham, M.D., East Orange, N. J.

Chairman of the Committee on Maternal Welfare

A major objective of the Sub-Committee on Maternal Welfare of The Medical Society of New Jersey is to reduce the number of deaths of mothers in childbirth. The number of deaths of mothers from this cause is known accurately, for every death is reported to the vital statistics division of the State Department of Health. For six years the committee has been well organized and has made studies and analyses of all maternal deaths in New Jersey, in order to determine:

1. Their causes, and the conditions under which they have occurred.

2. The factors which could have been controlled, by:

a. The mother.

b. The attending physician.

c. Community action in rendering assistance to the mother and the attending physician.

In its work the committee has had the cooperation of:

a. The Departments of Health of the State, and the local municipalities.

b. The Medical Societies of the State and the counties.

c. The practicing physicians, especially Family Doctors.

In its investigations the committee has prepared figures which may be compared with the periodic examinations of the financial conditions of banks. It has shown its findings by means of eight county maps and charts which show at a glance the maternal mortality record of the entire State of New Jersey, and of each county.

1. NEW JERSEY MATERNAL MORTALITY RATES

Exhibit number one is a graph which shows the number of maternal deaths in each one thousand births of living children during over six years beginning with 1931, when the Committee on Maternal Welfare was appointed, and ending with the year 1936.

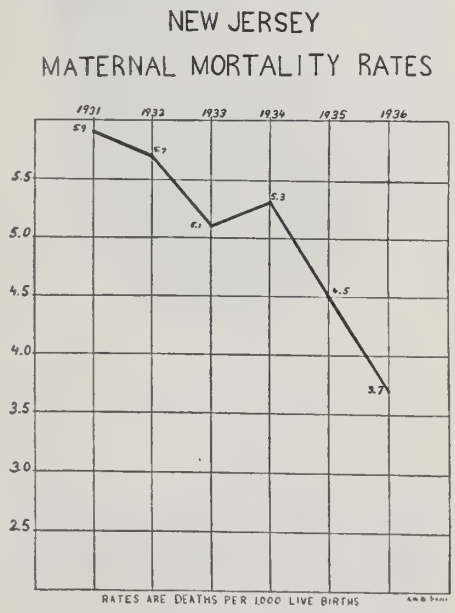


Exhibit 1

Downward trend of maternal mortality rates in New Jersey during the five-year period 1931-1936.

Beginning in 1931, the maternal mortality rate was 5.9; and the rate has decreased to 3.7 in 1936. The decrease has been progressive except for the year 1934, when it rose to 5.3, while in 1931 the rate was 5.1. This decrease for the five-year is greatly to the credit of the attending physicians and to their co-workers in nursing and welfare work.

2. COUNTY RATES FOR 1934-1936

Exhibit number two shows the maternal mortality rates of each county for the three years, 1934-1936. During this period the State rate was 4.5 deaths per 1000 live births.

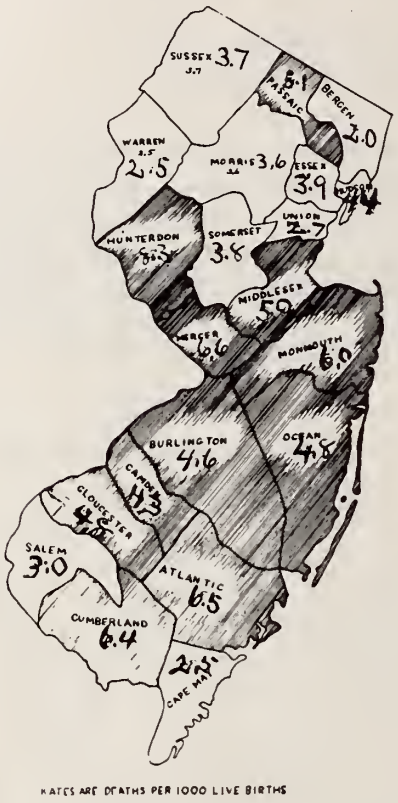


EXHIBIT 2

Maternal mortality rates by counties for the three-year period 1934-1936. State rate, 4.5. Shading indicates that the county rate is higher than that of the State.

The county rates varied from a maximum of 8.3, down to a minimum of 2.0 in Bergen County.

In ten counties the rates were below that of the State; and in eleven the rates were greater.

3. COUNTY RATES IN 1936

Exhibit number three shows the county maternal mortality rates for 1936—the sixth year of the State-wide activities of the committee: The State rate had fallen to 3.7.



EXHIBIT 3

Maternal mortality rates by counties for the year 1936. State rate, 3.7. Shading indicates that the county rate is higher than that of the State.

The county rates varied from zero in Cape May County, to a maximum of 5.7 in one county.

In sixteen counties the rates were below that of the State; and in five they were greater.

In five counties the 1936 rate was greater than that for their three-year period, 1934-1936; and in sixteen counties it was lower.

4. SEPTIC ABORTION

Considering specific causes of maternal mortality for the three-year period 1934-1936, *septic abortion* headed the list with a State rate of 0.88, as is shown on exhibit number four.

5. PUERPERAL SEPTICEMIA

Exhibit number five shows that the State rate for *puerperal septicemia* in 1934-1936 was 0.87—almost as high as that for septic abortion.

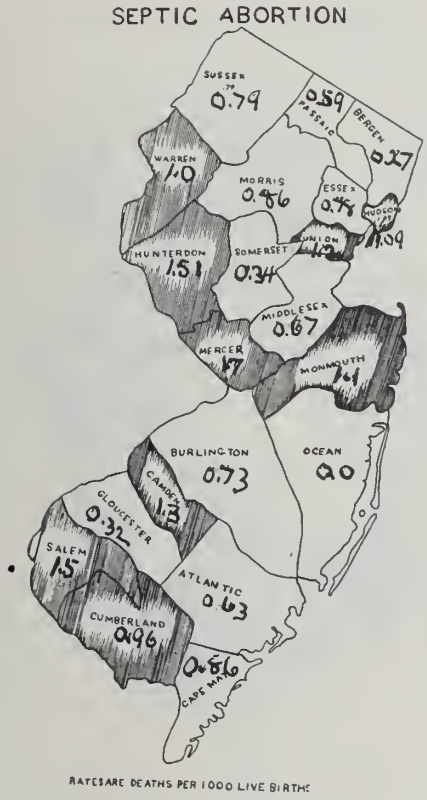


EXHIBIT 4

Maternal mortality rates from septic abortion, by counties, for the three-year period 1934-1936. State rate, 0.88. The shading indicates that the county rate is higher than that of the State.

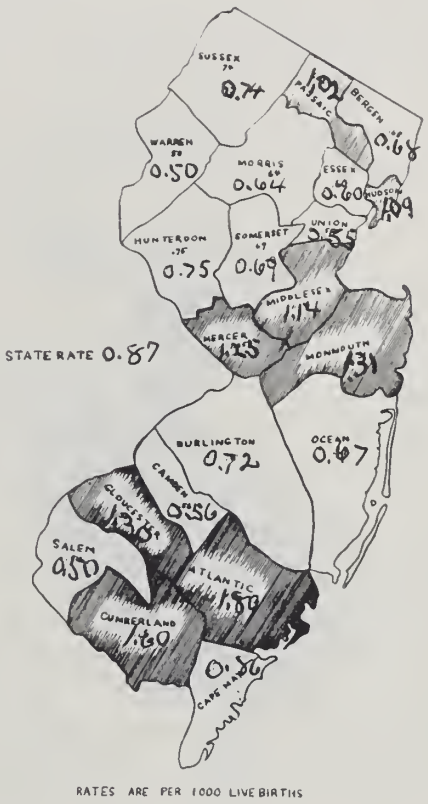


EXHIBIT 5

Maternal mortality rates for puerperal septicemia, by counties, for the three-year period 1934-1936. State rate, 0.87. The shading shows that the county rate is higher than that of the State.

Twelve counties showed a rate lower than that of the State; and nine a higher rate.

The rates for individual counties varied from a maximum of 1.7 to a minimum of zero.

In eight counties the rate was higher than that of the State, the maximum being 1.8; and in thirteen counties the rate was lower, but it did not fall to zero in any county.

6. TOXEMIA OF PREGNANCY

Exhibit number six shows the effect of *toxemia of pregnancy,* which was third on the list of specific causes of maternal mortality in 1934-1936, the State rate being 0.69.

In thirteen counties the rate was higher than that of the State, the maximum being 2.26; and in eight counties it was lower,—that in Salem being zero.

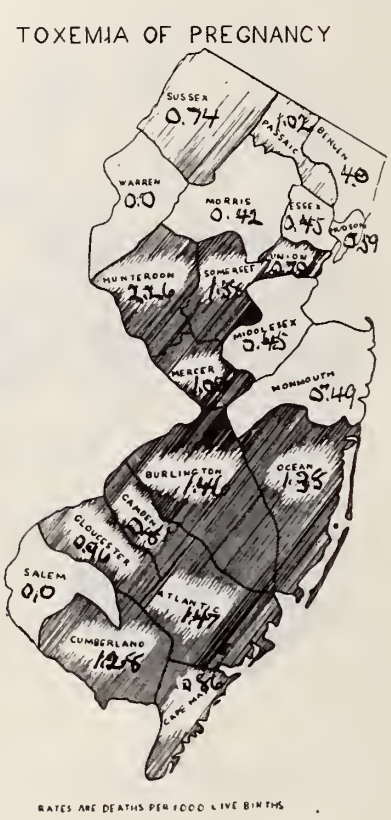


Exhibit 6

Maternal mortality rates for the toxemia of pregnancy for the three-year period 1934-1936. State rate, 0.69. The shaded counties have rates higher than that of the State.

7. PUERPERAL HEMORRHAGE

The fourth in the order of causes of maternal deaths during the three years 1934-1936 was *puerperal hemorrhage,*—the State rate being 0.49. The rates for the several counties is graphically shown on exhibit seven.

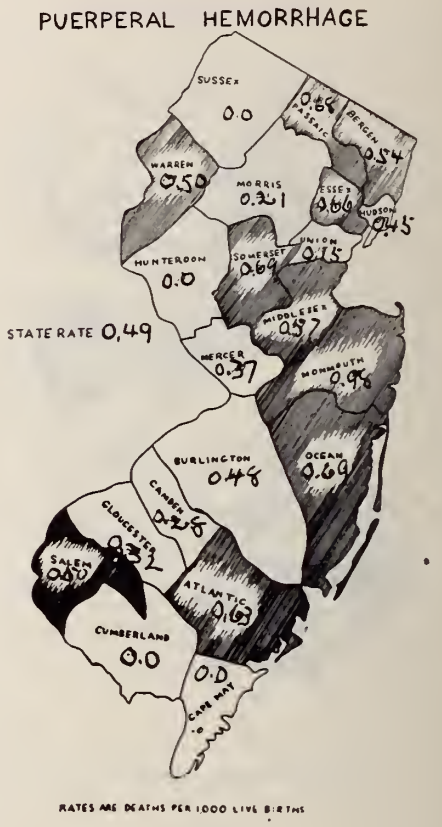


Exhibit 7

Puerperal hemorrhage as a cause of maternal deaths in New Jersey during the three-year period 1934-1936. State rate, 0.49. The counties which are shaded have rates higher than that of the State.

Eleven counties had rates higher than that of the State, the maximum being 0.98.

Ten counties had rates lower than that of the State; and in three they were zero.

8. ALL OTHER CAUSES OF DEATH

Exhibit eight shows that the State rate for all other causes of maternal deaths during the years 1934-1936 was 0.74.

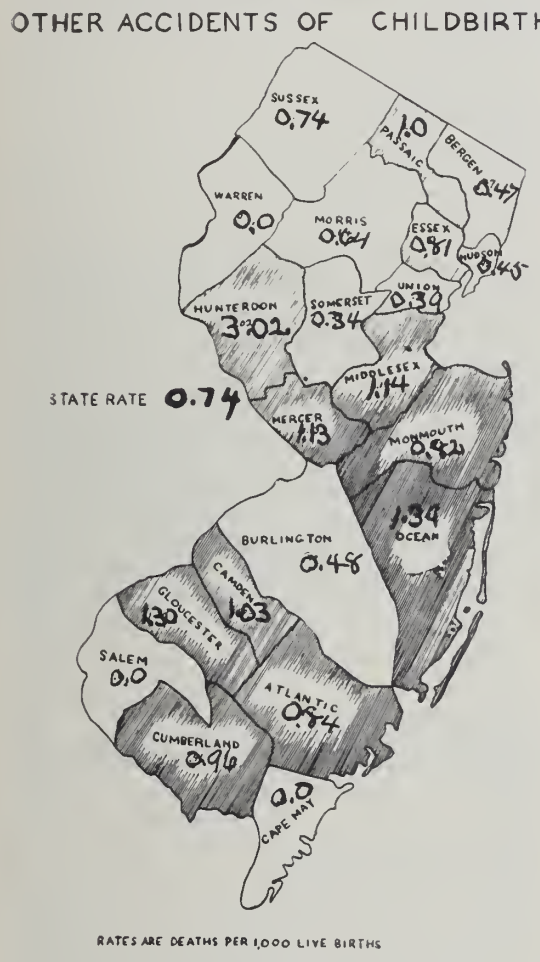


EXHIBIT 8

Maternal mortality rates from all other accidents of childbirth for the years 1934-1936. State rate, 0.74. The shaded counties have rates higher than that of the State.

In eleven counties the rates were higher than that of the State, the maximum being 3.02; and in ten counties the rates were lower. In three—Cape May, Salem, and Warren,—the rate was zero.

RESPONSIBILITY OF THE PHYSICIAN

Every physician in New Jersey is faced with the problem of conserving the lives and health of mothers in childbirth. He can prevent toxemias of pregnancy by prenatal supervision; and septicemias by better obstetrical procedures, and by educating the mothers. Puerperal hemorrhage is predominantly a condition for the physician to control at the time of labor.

MATERNAL MORTALITY IN 1937

While the reports for the three years, 1934-1936, show a progressive lowering of the maternal mortality rates in the several counties, the reduction has not been uniform, and in a few counties the rates have increased in some causes of deaths.

Moreover, the reports that have been received during the first half of 1937 indicate an increase in the number of maternal deaths, and that the State mortality rate for the year may show an increase.

Let every reader of this article study the maternal mortality record of his county, and then consider his own record in his private practice. The possibility is that if one of his maternity patients has died, he can prove that she had been negligent, or ignorant, or prejudiced, or unable to follow the doctor's advice. Every doctor therefore is under an obligation to *educate* his maternity patients, and to advise them to accept the services of the visiting nurse and the welfare worker when they are needed.

SCIENTIFIC EXHIBITS

THE SCIENTIFIC EXHIBITS OF THE 1937 ANNUAL MEETING

ARTICLE NUMBER TWO

EXHIBIT NUMBER TWENTY-ONE

KLINE TESTS FOR SYPHILIS

By Charles Robert Rein, M.D., New York City
New York Post-Graduate School and Hospital

The Kline flocculation tests demonstrated in this exhibit were all devised by Dr. B. S. Kline, Director of Laboratories, Mount Sinai Hospital, Cleveland, Ohio. These tests can be done on the routine inactivated sera, as well as with raw sera, defibrinated whole blood, chancre fluids, and spinal fluids.



Exhibit No. 18—The Kline Test for Syphilis

The materials necessary for the Kline tests are inexpensive. The microscopic slides (2 x 3 inches) as purchased are cleansed, and the necessary paraffin and wax rings mounted with a circular wick or special mould. The Kline antigen is a lipid obtained by precipitation in acetone at fifty degrees C. to thirty-seven degrees C., of concentrated absolute alcohol extract of beef heart powder (Difco). This antigen may be purchased * or prepared in the laboratory. The average yield of antigen from one-half pound of beef powder is from 35 to 40 c.c. Four and four-tenths cubic centimeters of the antigen emulsion are made from 0.1 c.c. of the antigen. One drop of this emulsion (approximately 0.008 c.c.) is used for each test. These various antigen emulsions, if kept at room temperature, are satisfactory for use for twenty-four to forty-eight hours after preparation.

After the sera are inactivated and the antigen emulsions are prepared, the actual tests can be performed in a few minutes. Eighteen sera, in duplicate, can be tested at one time (in about ten minutes). The test consists of adding one drop of the antigen emulsion to 0.05 c.c. of serum in the paraffin ring, and rotating the slide for four minutes. Finger blood can be collected and tested in less than ten minutes. Heating the serum is not required for the Kline finger blood tests. The results of all the slide tests are easily interpreted, because they are examined through the microscope at a magnification of about 120 times (low power, 16 mm. objective, eyepiece 12) and because the various degrees in change of the emulsions are much more apparent than when observed with the naked eye. The light is cut down as for the study of urinary sediments. The results may be reported in terms of "positive", "doubtful", and "negative", according to the degree of clumping and the size of the clumps. The details of the preparation of the antigen and antigen emulsions, as well as the description of all the Kline flocculation tests, are given in Kline's book.[1]

The United States Public Health Service, in coöperation with the American Society of Clinical Pathologists, devised an evaluation plan [2] to appraise the various modifications of the complement fixation methods and flocculation tests developed and used in the United States for the serodiagnosis of syphilis. The results of this evaluation showed that the more reliable flocculation tests were specific to the same degree, and more sensitive than the complement fixation tests. The committee expressed the opinion that "certain tests which may be performed rapidly on blood specimens appeared to yield results comparable to those

* La Motte Chemical Co., Baltimore, Md.

obtained with tests requiring a longer period for their performance".

The results of this recent serologic conference also made clear that certain tests were highly desirable as *diagnostic* tests, because of their high degree of specificity with satisfactory sensitivity; while others were desirable as *exclusion* tests possessing maximum sensitivity and satisfactory specificity. In this conference it was found that the Kline diagnostic heated serum test was highly specific, while the Kline exclusion heated serum test [3] was the most sensitive of all tests that gave less than one per cent false positive reactions in 468 presumably non-syphilitic persons.

Among the conclusions reached in this recent evaluation plan was the following: "There is some evidence that a properly performed highly sensitive flocculation test might be used routinely for the purpose of excluding the likelihood of syphilis. If a negative result is obtained by such a method, it is quite likely that it will be negative by any other method." The Kline exclusion tests is so highly sensitive that, when it is negative, it usually excludes the likelihood of syphilis. In addition, the test can be done in a few minutes with a small amount of finger blood. The Kline exclusion test is especially applicable for the detection of syphilis in donors, because it possesses maximum sensitivity with satisfactory specificity, and can be done in a few minutes with a few drops of easily collectable blood immediately prior to the transfusion.

Littman,[4] in 1932, reviewed 147,250 Kline tests performed in some sixteen clinics throughout the country and found the tests consistent with clinical findings in from 96 to 99 per cent of the cases. In addition, he found the Kline test to be more sensitive than the Kahn, Wassermann, and Hinton tests in various stages and types of syphilis.

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580 Fifth Avenue, New York, N. Y.

EXHIBIT NUMBER SIX

HEMORRHAGE IN OBSTETRICS.—CONGENITAL MALFORMATION OF THE HEART

By S. A. COSGROVE, M.D., and N. M. ALTER, M.D.
Margaret Hague Maternity Hospital, Jersey City, N. J.

The exhibit of the Margaret Hague Maternity Hospital, Jersey City, N. J., had a twofold purpose in demonstrating (1) one of the most important causes of maternal morbidity and mortality,—hemorrhagic conditions; and (2) one of the most important causes of neonatal death,—heart disease incompatible with life.

CAUSES OF MATERNAL DEATHS

A visual representation of statistics of maternal deaths within the five-year period of the hospital was made in the form of a cemetery. This demonstrated strikingly the three main causes,—sepsis, toxemia, and hemorrhagic conditions. To reduce the causes of hemorrhagic conditions was the purpose of this exhibit by demonstrating the possible causes during all periods of pregnancy,—ante-, intra-, and postpartum,—in order to improve the clinical and pathological diagnosis.

ABORTIONS,—AND SIMILAR CONDITIONS

In the early period of pregnancy, hemorrhage often means interruption of gestation; and therefore the diagnosis of abortion will be most obvious. Various phases of this process are demonstrated by pathological specimens,—complete abortion with fetus before placenta is formed, and incomplete abortion when placenta is retained, etc.

The exhibit also drew the attention to so-called missed abortions when the products of conception are not expelled. There were specimens on exhibit demonstrating mummification of fetus with hemorrhage and necrosis of placenta. These cases gave a negative A. Z. test.

It must be borne in mind that hemorrhage and so-called "blood clots" may not always be due to abortion.

The exhibit attempted to emphasize, particularly, how often recognition of the real condition can be missed, as for example, in the case



Exhibit No. 6—Hemorrhage in Obstetrics, and Congenital Malformations of the Heart. From the Margaret Hague Hospital.

of hydatidiform mole. So-called "blood clots" are discarded; whereas a thorough inspection may reveal the real nature of the pathological condition. The exhibit showed cases where only 15-30 grams of so-called "blood clots" contained the last remnants of a hydatidiform mole, expelled by patients in the hospital after admission for incomplete abortions.



Fig. 1.—Ruptured tubal pregnancy (interstitial) with four months fetus free in abdomen. Extensive decidual changes of uterine lining with hemorrhages.

ECTOPIC PREGNANCY

Specimens of ectopic pregnancy showed the causes of bleeding in this condition, which are also often misdiagnosed as abortion. One specimen demonstrated also the danger of vaginal examination in suspected ectopic without proper preparation for combating possible hemorrhagic and traumatic shock due to inadverent rupture during vaginal examination.

Near term ante-partum bleeding can be extreme, due to various types of early placental separation. The most important example is the placenta previa. Vaginal examination, so necessary in such conditions, may precipitate hemorrhages that might be extremely grave without proper preparation.

PATHOLOGICAL PLACENTAS

The exhibit demonstrated also examples of nephritic and eclamptic types of placenta with necrosis and hemorrhages, which extend from within the placenta to the decidual surface, causing premature separation. Some of these placental hemorrhages may be combined with extensive intramuscular hemorrhages of the

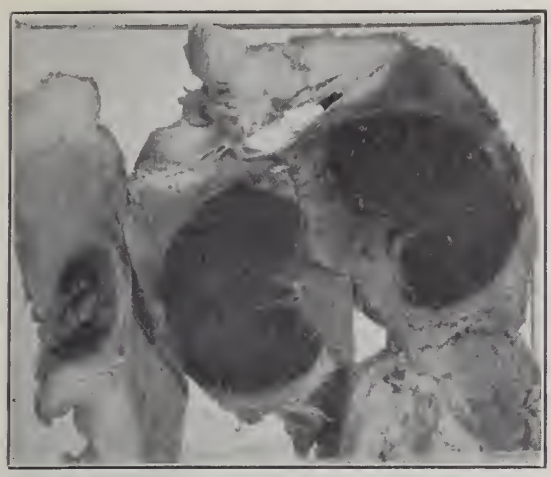


Fig. II.—Cross-sections of a placenta with extensive hemorrhages and necrosis in a case of nephritis.

uterus,—so called apoplexy of uterus (Couvelaire). The clinical picture in these cases is shock, as is also seen in cases of rupture of the uterus, which also may occur at the time of the delivery. Specimens of both conditions were included in the exhibit for the purpose of demonstrating the pathology, but clinically they were recognized only in the operating room or at autopsy table.

The purpose of showing these specimens was also to demonstrate that such grave emergencies can occur during delivery and the real pathology can be diagnosed only by visualization, therefore hospitalization should be preferred, where the proper set-up is possible.

BLEEDING, POST-PARTUM

The main causes of bleeding post partum were demonstrated by specimens, such as adherent placenta, late retained inclusion of secundines, inversion of uterus, tumors, and necrotizing endometritis. Tumors (adenomyosis, myoma, uterine malignancies, chorionepithelioma) may all cause hemorrhage directly or indirectly by precipitating other direct causes at any stage of pregnancy but perhaps most important in the post partum period.

NEONATAL DEATHS

The causes of neonatal death may not be revealed without a thorough autopsy. A series of congenital malformations of the heart were presented. These malformations were presented in various phases of misdevelopment during the formation of the vascular system.



Fig. III.—Apoplexy of uterus (Couvelaire) with extensive and diffuse hemorrhages over peritoneal surface of the uterus as well as throughout the uterine wall.

One of the earliest such phase was demonstrated in a specimen of *cor biloculare* with the persistent truncus instead of aorta and pulmonary artery, with only one ventricle and one auricle. An unusual specimen in the exhibit demonstrated the incompatibility with life in such cases as complete stenosis and atresia of the pulmonary artery; another, the reverse complete coarctation of the aorta, when the pulmonary artery had to carry the burden of the entire aorta. These cases were also demonstrated in the exhibit with drawings showing also the attempt of the system for physiological readjustment of the circulation.

Patent ductus arteriosus and foramen ovale were judged incompatible with life only when permanent and large venus shunts were produced, as demonstrated in the exhibit.

In a series of 500 cases of neonatal death, ten (two per cent) showed extreme congenital cardiac malformation, incompatible with life.

There were also specimens of cardiac malformations demonstrating conditions of lesser gravity compatible with life such as transposition of aortic and pulmonary trunks, etc.

An interesting type of heart disease was demonstrated in cases of pulmonary atelectasis, when the presence of a wide ductus arteriosus was explained on the base of physiological changes.

EXHIBIT NUMBER FOUR

TREATMENT OF GONORRHEA IN THE FEMALE BY MEANS OF SYSTEMIC AND ADDITIONAL PELVIC HEATING

By William Bierman, M.D., New York City

The rationale of the treatment of gonorrhea in the female by means of systemic and additional pelvic heating is based upon the fact that the gonococcus can be destroyed within its human host by means of heat. The highest systemic temperature which may be maintained for a long period of time is 106.7° F. (41.5° C.). At this temperature level experiments in vitro have shown that it is possible to destroy the various strains of the organism in a period of time varying from six to thirty hours. At 109.3° F. (42.8° C.) the gonococci can be destroyed in about one-half the time required for a thermal lethal effect at 106.7° F. (41.5° C.).



Exhibit No. 4—Treatment of Gonorrhoea in the Female by Pelvic Heating.

By means of a special technic for the administration of local pelvic heating through the use of the conversive energy of the diathermy current, it is possible to establish a temperature level of about 109° F.-110° F. in the pelvis. It is recognized that immune factors exert an injurious effect on the diplococcus in addition to the direct influence of temperature elevation.

The indications for the treatment are the presence of a gonorrheal condition and its complications in the adult female. Cases with gonorrheal arthritis or salpingitis respond as well as do uncomplicated lower genital tract infections.

The technic of the treatment consists of two parts: First, the systemic temperature is elevated to the desired level, 106° F. by means of radiothermy, and diathermy, electric light cabinets, hot baths, or any combination of these methods. Second, the additional pelvic heating is then applied. Either diathermy or short-wave may be used. A special vaginal electrode of proper length is indispensable. This electrode has been patterned after plaster casts made of the adult vagina. The electrode is constructed in four sizes varying in length from 2¾ to 4¼ inches. A thermometer records the electrode temperature, which is kept at all times between 109° F-110° F. We have found it advantageous to use a specially constructed thermometer which permits of easy reading of temperatures at a distance of several feet.

In the administration of diathermy to the pelvis we have found it advisable to use a system of dispersive electrodes, which avoids local overheating of tissue. This system consists of three metal belt electrodes, one fastened about each thigh, and the third placed around the waist. These three electrodes are connected to one terminal of the diathermy machine. Interposed along the course of the cords going from the dispersive electrodes to the diathermy machine we have placed milli-ampere meters and resistances so as to permit us to shift the current load from one place to another as indicated. An additional fourth dispersive electrode can be used by placing a large metal plate upon the back so that it connects with the posterior portion of the metal belt going around the waist. The period of local heating is maintained for about six or seven hours. The systemic temperature is held elevated for about twelve hours. Vaginal short-wave treatment may be substituted for diathermy. The dispersive electrode may be held at some distance either above or below the patient. A variable condenser may be placed in the course of the electric cord going to the vaginal electrode.

The results obtained with this combination of general hyperpyrexia and additional pelvic heating in the treatment of 125 women suffering from gonorrhea were as follows:

In our first series, 117 were freed of gonococci (93 per cent). In our first series, sixty-seven women received from five to six hours of general hyperpyrexia, during three and a half to four hours of which additional pelvic heating was administered. Sixty-two of these sixty-seven cases were freed of gonococci in an average number of 2.3 treatments per patient.

In our second series, fifty-eight women received twelve hours of hyperpyrexia, including

six to eight hours of additional pelvic heating. Fifty-five of these women were freed of gonococci after an average of 1.4 treatments per patient. With the disappearance of gonococci after treatment, the purulent cervical and urethral discharges disappeared. If a discharge persisted, we frequently found the trichomonas to be the cause. In complicated febrile cases the temperature returns to normal. Tubal or joint exudates rapidly subside. Pain in the abdominal or in the joint area disappears, often during the first treatment.

EXHIBIT NUMBER EIGHTEEN

ADHESIONS COMPLICATING PNEUMOTHORAX THERAPY

By J. W. CUTLER, M.D.
Henry Phipps Institute, University of Pennsylvania

The exhibit was designed to describe and illustrate the problem of adhesions as it is encountered in the treatment of pulmonary tuberculosis, and consisted of transparencies, x-ray reproductions, translight-colored drawings, instruments used for severing adhesions and an experimental pleural cavity phantom.



Exhibit No. 18—Adhesions Complicating Pneumothorax Therapy.

The fact was made clear that pleural adhesions are the most important single factor in the failure of pneumothorax therapy and that internal pneumolysis introduced by Jacobeous in 1913, can convert many of these failures into brilliant successes. Statistics were presented to show that more than 20 per cent of tuberculous patients of the general type in which a pneumothorax can be established can benefit from this operation and that the prognosis of advanced tuberculosis can be materially improved. This should make internal pneumolysis a common procedure and one to be employed as a matter of choice wherever it can shorten convalescense, render open cases negative more quickly or simplify the pneumothorax treatment by eliminating the necessity for positive pressure refills and permit longer intervals between refills. The evolution of this operation thus parallels that of pneumothorax treatment itself in that the trend is to employ it early in the course of treatment and to widen its indications.

Emphasis was placed on the principles that should guide one in determining when operative procedure is necessary, the best time for operation, and the type of adhesion that is safe to sever, together with criteria for selection of pneumolysis rather than some other type of operation.

Illustrated case histories were presented to demonstrate that one should not operate during the first two or three months of a pneumothorax, not to wait much longer than four to six months, not to attempt too much at one cutting, to support the contralateral lung if it is the seat of active disease with a phrenic nerve operation or a partial pneumothorax before undertaking a difficult intrapleural pneumolysis, and to keep in mind that it is not necessary to sever all adhesions or even all of one adhesion in order to close cavities.

The frequency and management of the various complications such as tuberculous empyema, spontaneous pneumothorax, hemorrhage, loss of pleural space, pleural effusions and subcutaneous emphysema were fully illustrated as well as the various types of adhesions encountered in the general run of tuberculous patients.

A detailed and graphic presentation of the modern single cannula technic featuring the Cutler forceps thoracoscope, thoracotome and other instruments developed by the author, with the instruments available for inspection and trial in an experimental phantom completed the exhibit.

STATE SOCIETY ACTIVITIES

WELFARE COMMITTEE

A meeting of the Welfare Committee was held on the afternoon of Sunday, August 8th, 1937, in the Berkeley-Carteret Hotel, Asbury Park, with twenty-six members present, and the Chairman, Dr. Hilton S. Read, presiding.

A NATIONAL HEALTH POLICY

The principal object of the meeting was the consideration of the subject "A National Policy in Public Health", which had been discussed in a meeting of the Board of Trustees on June 9, and of the Welfare Committee on June 27, and the decision had been reached that the Persident's Cabinet should draw up a formal statement which should express the attitude of The Medical Society of New Jersey toward the national health policy of the American Medical Association. (Journal, July, 1937, pages 459, 462, and 465.)

The Cabinet presented a four-page resolution approving the decision of the American Medical Association in regard to the proposals of the New York State representatives at the annual meeting in June, but with the reservations that the Ten Principles adopted by the A. M. A. in 1934 be included as a part of the decision, and that certain principles announced by The Medical Society of New Jersey also be included.

The Welfare Committee approved the resolutions of the President's Cabinet, and directed that they be sent to the Trustees; and on their approval, that they be forwarded to the American Medical Association as the official opinion of The Medical Society of New Jersey.

NEWSPAPER ADVERTISEMENTS OF MEDICAL BOOKS

Dr. Read read some correspondence which the President had had with Dr. Olin West of the A. M. A. in regard to advertising of medical books in the lay press. Dr. West's viewpoint coincided with that of the Welfare Committee.

CARE OF INDIGENTS

Dr. C. H. Schlichter, Chairman of the Committee on the Medical Care of the Indigent, submitted a draft of a suggested agreement with the State Finance Assistance Commission, proposing a plan that is similar to that under which the E. R. A. work was satisfactorily conducted. The Welfare Committee referred the agreement to the Trustees for approval.

COMMUNICATION TO THE AMERICAN MEDICAL ASSOCIATION

As a result of the resolution presented by the New York State Medical Society, the statements of Senator J. Hamilton Lewis, and the action taken by the House of Delegates of the American Medical Association on June 9th, 1937, the President felt that it was essential that The Medical Society of New Jersey express its approval or disapproval officially of the action taken by the A. M. A. For that reason a meeting of the Welfare Committee was held on June 27th in order that as large a number of the Society as possible could take part in the discussions. As a result of that meeting the matter was referred to the President's Cabinet to draw up a suitable set of resolutions, clearly stating the attitude of The Medical Society of New Jersey, and these resolutions when prepared were to be presented at a second meeting of the Welfare Committee to be held on August 8th. After receiving the approval of the Welfare Committee, the resolutions were passed on to the Board of Trustees; and with their approval were sent to the Officers and Trustees of the American Medical Association.

Copies were also sent to the Secretaries of the other forty-seven State Medical Societies, to the New Jersey Senators and Congressmen in Washington, and to Senator J. Hamilton Lewis.

The resolutions of the Welfare Committee and the Board of Trustees were as follows:

TEXT OF THE NEW JERSEY COMMUNICATION TO THE AMERICAN MEDICAL ASSOCIATION

To the Officers and Members of the Board of Trustees of the American Medical Association:

The following resolutions were forwarded by the Welfare Committee of The Medical Society of New Jersey to its Board of Trustees, and were adopted by the Board on August 20th, 1937:

I. That The Medical Society of New Jersey wishes to express its approval and accord with the manner in which the proposals of the New York Delegation were disposed of by the House of Delegates of the American Medical Association on June 9th in Atlantic City with certain reservations.

Inasmuch as the American Medical Association, as a national organization, is composed of and derives its power from forty-eight component State Societies, it is natural to assume that the central organization desires to carry out the policies and achieve the aims of the majority of its component organizations. We, therefore, assume that the Officers and Trustees of the parent organization are anxious to hear as promptly as possible from the component Societies as to their reaction to any stand taken by the House of Delegates during an immediate past convention.

The Medical Society of New Jersey therefore feels it is not only its privilege but its duty to acquaint the Board of Trustees and Officers of the American Medical Association of its attitude in regard to the resolution passed at the Eighty-eighth Annual Session of the House of Delegates in Atlantic City on June 9th, 1937, and reported in the Proceedings of the Atlantic City Session on page 2220 as follows:

"The American Medical Association reaffirms its willingness on receipt of direct request to coöperate with any governmental or other qualified agency and to make available the information, observations and results of investigation together with any facilities of the Association."

This rather broad offer, unless properly interpreted, might very readily be construed as implying a willingness on the part of the American Medical Association to participate in the socialization of medicne. To any such statement as the above should be appended a statement of the Ten Principles to be followed in meeting the problems of medical service in the United States which the American Medical Association adopted at its Eighty-fifth Annual Session:

First: All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control.

Second: No third party must be permitted to come between the patient and his physician in any medical relation. All responsibility for the character of medical service must be borne by the profession.

Third: Patients must have absolute freedom to choose a legally qualified Doctor of Medicine who will serve them from among all those qualified to practice and who are willing to give service.

Fourth: The method of giving the service must retain a permanent confidential relation between the patient and a "family physician". This relation must be the fundamental and dominating feature of any system.

Fifth: All medical phases of all institutions involved in the medical service should be under professional control, it being understood that hospital service and medical service should be considered separately. These institutions are but expansions of the equipment of the physician. He is the only one whom the laws of all nations recognize as competent, to use them in the delivery of service. The medical profession alone can determine the adequacy and character of such institutions. Their value depends on their operation according to medical standards.

Sixth: However the cost of medical service must be distributed, the immediate cost should be borne by the patient, if able to pay, at the time the service is rendered.

Seventh: Medical service must have no connection with any cash benefits.

Eighth: Any form of medical service should include within its scope all qualified physicians of the locality covered by its operation who wish to give service under the conditions established.

Ninth: Systems for the relief of low income classes should be limited strictly to those below the "comfort level" standard of incomes.

Tenth: There should be no restrictions by non-medical groups on treatment or prescribing unless formulated and enforced by the organized medical profession.

II. The Medical Society of New Jersey pledges its continued coöperation with Federal and State Departments of Health, as now constituted. We believe:

A. That Federal government control in the practice of medicine should be confined to:

1. Medical service in the Army, Navy and Marine Corps.

2. Hospitalization and medical care rendered to war veterans suffering from disabilities, the direct result from wounds or diseases incurred while on active duty, or when hospital study is indicated to determine the eligibility for pension.

3. Public Health Service in its strict meaning:

a. Epidemiology.
b. Control of occupational disease.
c. Control of individuals or conditions that are a menace to the general health of the community.
d. Research with regard to any of the above.

4. That local government control be confined to the maintenance of institutions for the care of the insane, epileptics and those having communicable diseases and needing isolation.

B. That all other phases of the practice of medicine should be free from governmental supervision or control.

C. That the principle of caring for the indigent by the use of public funds from various sources for the payment of physicians for their services on a reduced fee basis should be supported. These funds, however, should be administered by local agencies with provision for the preservation to the patient of free choice of a legally licensed physician and an institution where hospital service is necessary.

D. That any national health policy should meet the approval of the American Medical Association and any plan for the use of public funds in the promotion of such policy in any locality should be approved by local units of organized medicine.

E. That the medical care of those gainfully employed but in the so-called low-wage group should not receive government aid but be cared for by private physicians through a mutual adjustment of fees on the deferred payment basis.

F. That compulsory health insurance or any other form of State medicine is not suited to the American people and would be detrimental to both the deliverer and recipient of such services.

It is therefore the earnest desire of The Medical Society of New Jersey that the American Medical Association be mindful of its own principles stated in 1934 and qualify its willingness to coöperate with "any government or qualified agency" depending upon whether or not the plans of such agency are within the bounds so stated.

These resolutions are respectfully submitted to the Officers and Trustees of the American Medical Association.

MEDICAL SURVEY OF COUNTIES

NUMBER ONE—HUNTERDON

Hunterdon County lies for twenty miles along the east side of the Delaware River, beginning about ten miles north of Trenton, the State Capital, and reaching about twenty-five miles inland. It has an area of 437 square miles, being seventh in area among the twenty-one counties of the State. The county is crossed by two main highways running north and south, and two east and west.

A person riding in any direction through the county will pass through few villages, and will gain the impression that it is a beautiful rolling land of prosperous farms which are outlined and framed with large trees. A physician can easily reach any part of the county by automobile.

POPULATION

The population of Hunterdon County, according to the census of 1930, is 34,728, or an average of eighty per square mile. In this respect a comparison of Hunterdon County with some other counties, as follows:

	Population per Square Mile
Sussex	52
Ocean	54
Hunterdon	80
Salem	107
Burlington	115
Warren	136
Cumberland	139
Somerset	240

The distribution of population, according to the census of 1930, is as follows:

Urban	7,247
Rural—Farm	11,581
Rural—Non-farm	15,900
	34,728

The people are distributed fairly evenly over the whole area of the county, and the largest centers of population are shown in the following table:

	Population	Number of Doctors
Lambertville	4,518	5
Flemington (County seat)	2,729	5
Frenchtown	1,189	3
White House Station	1,000	2

The people are predominantly farmers and dairymen, and make use of the greater part of the more productive land. The industrial plants, aside from creameries and gristmills, have always been few; and at present they consist of two iron and steel rolling mills, a shirt mill, a

porcelain sparkplug factory, one for the manufacture of rubber goods, a silverware factory, and a knitting mill for hosiery.

Physical and economic conditions have made Hunterdon a county with a stabilized population, and a uniformity of occupation and habits of life. Its slight variation in population during the last eighty years is shown in the following table:

Year	Population
1850	28,900
1860	33,654
1870	36,963
1880	38,570
1890	35,355
1900	34,507
1910	33,569
1920	32,885
1930	34,728

The present population of Hunterdon County is almost the same as its average during nearly a century.



Distribution of physicians in Hunterdon County.
● — Members of County Society.
+ — Non-members of County Society.

NUMBER OF PHYSICIANS

The total number of physicians in Hunterdon County, listed in the Tri-State Directory of New Jersey, New York and Connecticut is thirty-eight; but from that should be subtracted the six who are full-time members of the staff of the New Jersey Tuberculosis Sanatorium at Glen Gardner, leaving thirty-two as the number whose field is Hunterdon County proper. There is, therefore, one doctor for each 1085 inhabitants of the county. In the entire State of New Jersey the proportion is 865 persons per doctor.

YEARS OF PRACTICE

The number of years in which the thirty-two private practitioners of Hunterdon County have been in practice is shown in the following table:

Year of Graduation	Number of Years in Practice	Number of Doctors
1876	61	1
1877-1887	50-59	2
1888-1897	40-49	4
1898-1907	30-39	7
1908-1917	20-29	7
1918-1927	10-19	5
1928-1937	1-9	6

Fourteen physicians have been in practice twenty years or less; and eighteen for more than twenty years.

DISTRIBUTION OF PHYSICIANS

Hunterdon's thirty-two physicians are located in seventeen centers which are scattered over the county with a fair degree of evenness, so that there is scarcely a place removed more than five miles from a physician. Five doctors are located in Flemington, and two practice in Clinton, while only four are credited to Lambertville,—the most populous municipality in the county. Frenchtown is credited with three physicians, and High Bridge and Bloomsbury each with two. Each of the other ten doctors is alone in his village.

HOSPITALS

There is no hospital in Hunterdon County except the New Jersey State Sanatorium for Tuberculosis in Glen Gardner, which receives patients from the entire State. The nearest hospitals are the Somerset Hospital in Somerville, the Warren Hospital in Phillipsburg, and the three general hospitals in Trenton, each about ten miles from the border of Hunterdon County.

THE COUNTY MEDICAL SOCIETY

Hunterdon County has an active County Medical Society with twenty-one members, according to the Official List of 1937. This is about two-thirds of the practicing physicians of the county. Nearly every physician in active practice belongs to the County Society, as do the majority of the members of the staff of the Glen Gardner Sanatorium.

The Society holds regular meetings on the fourth Tuesday of January, April, July, and October, that of April being the annual meeting. The newly elected officers take office at the end of the annual meeting of the State Society, in accordance with the suggestions of the State Society.

In the appointment of committees the Society also follows the plan of the Welfare Committee of the State Society, its principal committees being those on Legislation, Public Health, and Medical Practice.

In 1937 the Society adopted the plan that its regular meetings shall be devoted to Society work, while special meetings are held to discuss scientific subjects. For example, the meeting of July 27 was on the subject of "The Field Physician, His Duties and the Responsibilities of the County Society for His Choice". (August Journal, p. 536.)

The Society usually meets in the morning and closes with a social dinner in the early afternoon, in time for the members to attend to their calls. A large percentage of members attend the meetings regularly.

PUBLIC RELATIONS

Since the population of Hunterdon County is unusually homogenous and scattered, it has few health organizations.

The Red Cross has a county organization, with branches in the principal centers of population. It coöperates with practically all the local organizations, such as the County Medical Society, school officials, the American Legion, the tuberculosis association, and several churches. All these organizations send representatives to a "Council", which collects and disburses funds, and employs a field nurse. A considerable part of the time of the nurse is occupied in transporting patients to hospitals, especially children who require minor operations, such as tonsilectomies.

The County Medical Society undertook the promotion of the "Public Health Hour" for giving immunizations in their offices; but since the population is scattered, the physicians advocated the plan that the parents should bring their children to centers of easy access, to each of which a physician is assigned, and is paid by the local organizations, such as school districts, while the nursing service is supplied by the Council. Flemington also has a school nurse. This plan is working well, and has the support of the physicians.

There are four child welfare stations in the northern part of the county, each under the management of the Child Welfare Division of the State Department of Health. Two Baby Keep-Well Stations are maintained, with the support of the family doctors.

The system of public health service is well adapted to the needs of the scattered population and the physicians are satisfied because they receive pay for a large part of their public health work, although they also contribute to its upkeep.

The only organized welfare work is that of old-age relief, which is in charge of a supervisor whose headquarters is in Flemington.

The Medical Society of Hunterdon County has a unique opportunity to direct all public health and welfare services. The doctors are intimately acquainted with the people in the county and understand the local needs of every community. They have the opportunity to direct the manner of establishing and conducting new forms of service, and they show a willingness to advise the lay workers in their activities; and the lay workers too are coöperating with the physicians.

The Hunterdon County Medical Society will nominate a Feld Physician to be appointed by the State Department of Health. His principal duty will be to study the services offered under the Federal Security Law, and give advice to the local physicians regarding the assistance which is available to them in handling difficult cases and dependent patients, especially in Maternal Welfare and Child Hygiene. When the service is established, the Hunterdon County Medical Society can be the center around which all the public health welfare work in the county can revolve.

HISTORIC BACKGROUND

The members of the Hunterdon County Medical Society are the inheritors of the fruits of the wisdom of their early predecessors who established the Society on June 12, 1821, as a District Branch of The Medical Society of New Jersey. When the State Medical Society was established in 1766. Hunterdon was the most populous county in New Jersey, and by the census of 1784 it had over 18,000 inhabitants, who were sreved by seven physicians whose names and addresses are known, and by more whose identity is lost.

DR. JOHN BLANE

The historian who perpetuated the memory of the early physicians was Dr. John Blane, whose obituary is printed in the Transactions of the State Society of 1886, page 147. He was born July 7, 1802, in Middlesex County, and studied medicine with Dr. W. D. McKissack, of Millstone, who was one of the great leaders of The Medical Society of New Jer-

sey, becoming President in 1826. He passed his medical examination before the censors of the Somerset County Society in 1827. He practiced medicine in Clarksville, and later, from 1831 until his death, in Perryville, where he died on June 18, 1885.

Dr. Blane was a great leader of the Hunterdon County Medical Society and of The Medical Society of New Jersey, being elected President of the State Society in 1861, and serving with unusual distinction.

Dr. Blane ranks with Dr. Stephen Wicks as a born historian. He compiled a list of all the physicians who practiced in Hunterdon County up to the year 1872, when the State Society published his 110-page history of the Hunterdon County Society as a part of the Transactions of the State Society of 1872. This is incomparatively the best history of a New Jersey County Medical Society that has ever been written, for it contains a record of every known physician who practiced in Hunterdon County up to the year 1872. To read this history will be an inspiration to every physician in Hunterdon County. From it the following facts have been compiled:

In 1800, when the population was 21,000, there were fourteen physicians whose names and addresses are known, practicing within the present county limits.

In 1826, the year of the founding of the Hunterdon County Medical Society, there were nineteen physicians practicing in the county whose names, places of practice and dates are known. There were more than nineteen physicians in the county, since there were nineteen charter members of the County Society.

In 1872, when Hunterdon County had a population of nearly 37,000, there were fifty-four know physicians who were practicing in thirty centers.

The decline in population and in the number of practicing physicians since 1872 is not to be interpreted as any lowering of the standards of medical practice, or a lessening of the opportunities of the people to obtain efficient medical service. On the contrary, the system of perfect highways, and the common use of the telephone and the automobile enable the physicians of the county to give far better service than ever before.

DR. OBADIAH H. SPROUL

A co-worker and close friend of Dr. Blane was Dr. Obadiah H. Sproul, President of the State Society in 1894, whose biography was printed in the Journal of June, 1937, page 396. He was just starting to practice when Dr. Blane was in his prime, but he carried on the work in which he was inspired by his illustrious predecessor.

A PROJECT FOR THE COUNTY SOCIETY

A most commendable project for the Hunterdon County Medical Society would be to undertake further research into the lives of Drs. Blane and Sproul. There must be many physicians and other persons who remember Dr. Blane, and still more who were associates of Dr. Sproul. It is especially desirable to obtain a likeness of Dr. Blane to publish in the Journal and to hang on the walls of the Executive Offices in the gallery of ex-Presidents. Research into their lives and work will also reveal the names of other physicians whose memories well deserve perpetuation. The deeds of the illustrious practitioners of Hunterdon County done in the days of meager professional facilities will be an inspiration to their present-day successors, whose opportunities are practically unlimited.

OPINIONS AND PLANS

ABSTRACTS FROM OTHER MEDICAL JOURNALS

REGIMENTATION IN MEDICINE

By Thomas R. Boggs, M.D., Baltimore, Maryland

Abstract of the President's Address before the Association of American Physicians, May 4, 1937, published in the Transactions of the Association, 1937, Vol. LII.

The Medical Profession is feeling the pressure of new philosophies in human relations, especially the trend toward its compulsion, by organized efforts, into a conformity called "Standardization of practice". While the proposed standardization has excellent ideals as its rallying point, yet in its logical development it may lead to bureaucratic stereotypism, far worse than the evils which it is intended to correct.

Some fourteen organizations have been incorporated during the last twenty years for the certification of individual physicians as specialists in the various fields of medicine. The driving motive of the incorporators was a sincere desire to improve the quality of medical service to the community,—the ideal being that by means of the certifications the public would be made aware of the competence of a given doctor in his specialty; and conversely by implication, the incompetence of those not certified. In order to coördinate the scope and methods of these boards, a super-board has been incorporated to direct the general trend of the standardization, and centralize the efforts to put it in effect.

THE INTERNIST

We are faced with a proposal to standardize the term "Internist", and to certify those whom the boards consider to be competent to fullfil the implications of that title. No examinations, questionnaires, evidence offered, and related documents can determine who is an internist, and who is not. An internist's recognition as such rests upon the concensus of opinion of his professional colleagues and trainers that he is so qualified. His proven value to his colleagues and patients is the only adequate test.

The test of active, open competition with qualified professional men will soon reduce the pretender to his proper level, and minimize the potentialities for harm that he may have. The effort at an artificial standardization by formula may do fundamental damage.

The general qualification for certification of a candidate is that he must be "A broadly experienced physician". At the organization of the system, a number of physicians who were in good community standing, and had graduated before a specified date, were admitted as "Internists de facto", on the payment of the required membership fee. Future aspirants for certification must have spent certain times of resident service in acceptable hospitals, and have taken graduate courses in internal medicine in properly equipped institutions. It is evident that, in the education of the aspirants, considerable expense must be incurred, either by the aspirant or by the teaching institution.

The author comments:

"Thus we may see the Boards of Trust and of Administration of Hospital and Medical School surrendering their judgment and their responsibility to the dictation of private corporations with no responsibility, under a type of urging which really amounts in plain words to a potent threat. The trend of the plan seems on close inspection to contain possibilities of method which strike at the very roots of medical education by substituting the extra legal demands of certificating bodies, for the considered plans and policies of those properly entrusted with medical education and training.

"Already hospitals, and perhaps next, medical schools, are requested to appoint only certificated individuals to leading positions in the various departments. Would agreement to this not put a dangerous and unbearable limitation on the academic freedom of choice?

"Some special societies are limiting membership to the certificated. Such limitation might conceivably spread to sections of the American Medical Association, State associations, and even to desirable media for publication.

"Lastly, I ask you to consider the historic evolution of such agencies for reform in which operation must devolve to an extent upon a paid secretariat. The able zealot, fired by desire to make something better, dies, or tires of the effort and sacrifice of his time, and ultimately the application of the scheme becomes a stencil in the hands of a bureaucrat incapable of judging or evaluating

justly. I commend to you the words of Dr. Adolf Meyer in his Presidential Address to the American Psychiatric Association in 1928. He discussed at length methods for the improvement of psychiatric training and of service to the public, and concluded in part as follows: 'We want plastic and progressive standards rather than a set form; we want the right to individuality, but with recognition of a responsibility for a consensus.'

"We, the oldest National Society of Internists, have been and are moving toward a goal of high quality in the field of internal medicine. Shall we continue our work as in the past fifty years which have accomplished so much; or shall we join in a movement to bring about a millenium by force, with the new evils which ever accompany such efforts?

"Let us rather, in the words of St. Paul, '* * * be able minister of the New Testament, not of the letter; but of the spirit: for the letter killeth, but the spirit giveth life' (2nd Corinthians, iii, 6)."

HOW MUCH HEALTH WILL THE PUBLIC TAKE?

The May, 1937, issue of Nassau Medical News, the monthly publication of the Medical Society of the County of Nassau, New York State, has an editorial on the subject "How Much *Health* Will the Public Take?" The editorial confirms the impression gained by attending the Conference on Venereal Disease Control in New Brunswick on May 18, at which over 1300 persons, mostly educated women, were present and expressed themselves freely and without the least embarrassment. (Jour., June, 1937, page 491.) The Nassau County editorial is here reproduced in its entirety.

Every once in a while something happens which brings health workers and physicians up short and demands a re-appraisal and re-alignment of our ideas as to what we can do, and what we should do in the matter of health education of the public. Such a jolt is contained in a recent communication to this Society from an organization of women in one of our North Shore villages.

SYPHILIS

Inspired by the recent publicity given nationally and locally to the subject of syphilis, The Manhasset Health Association asked us to furnish a speaker who would discuss at one of their meetings the question of congenital syphilis. One of our members who is specially trained in pediatrics accepted this assignment and went to their meeting, rather wondering how far he might go in discussing what but yesterday was considered a "delicate" subject. To his surprise he found an audience harboring a little feeling of resentment—not because of what he had to tell them,—but because they had not been told sooner. The doctor pointed out that although a routine Wassermann test on all pregnant women would disclose many unsuspected cases of syphilis and make possible the safe birth of many babies who would otherwise be lost or damaged, such a routine test would not be possible in private practice, because the mothers would resent the implication that they might be infected and would not permit the test to be made.

A few days later we received a letter from the president of this organization thanking us for making available to them the information which they considered so valuable, and taking the medical profession to task for not offering this service to all mothers as a routine part of their care during pregnancy. Enclosed with the letter were the following resolutions adopted by the association:

"The Manhasset Health Association wishes to go on record as recommending to the medical profession of Nassau County that all doctors establish the taking of blood Wassermann tests as a routine procedure in the office and hospital."

This is an unusual and important recommendation. It is an unsolicited opinion from a group of representative club women with an enlightened viewpoint; but it indicates a change in feeling from the old-time prudery to a frank and open consideration of syphilis. The opinion of these women is a challenge to any doctor who has been holding back on the taking of such tests because he thought his patients would feel offended.

Less than three months ago a representative of one of our metropolitan newspapers refused a publicity release we had prepared on the subject of syphilis because the newspaper in question is a family newspaper. "But," we pointed out, "syphilis is a family disease." Today that same evening paper carries in its news columns reports of meetings where syphilis and gonorrhea are discussed, and the diseases are mentioned just that way, not as "social diseases" or "social hygiene problems," and we haven't heard of any families being disrupted either. Surely the way is now wide open for the medical profession to attack this

problem both clinically and with preventive education.

CANCER

A similar situation exists in the matter of cancer, particularly in cancer of the female breast and reproductive organs. More women than men suffer from cancer because of the high incidence of the disease in these locations: 33 per cent of the cancers in women occur in the breast and 26 per cent occur in the uterus, chiefly in the cervix. Cancer in either of these locations lends itself readily to early diagnosis and responds very well to treatment, but late diagnosis carries with it an almost hopeless outlook. Cancer of the breast treated while the disease is confined to breast tissue has a favorable outlook of between 70 and 80 per cent, but drops to 20 per cent when the disease has invaded adjacent tissue or has metastasized to the lymph nodes. Cancer of the cervix presents an even more favorable outlook when treated in its initial stage, but late cases have almost zero chance for permanent cure. Yet when speakers go out to women's clubs under the auspices of the Cancer Committee, they meet the complaint that "my doctor never examines my breast and he never suggests an internal examination".

SOLICITING PATIENTS

It certainly is true that a few years ago a doctor might have expected to meet considerable opposition to any suggestion of a Wassermann test or an examination of the breasts and pelvis of a woman who presented herself for a routine check-up. Today the situation is decidedly different; the newspapers, the women's magazines and their club lecturers all face these medical facts squarely and discuss them freely. Has the time not arrived when we should re-evaluate the amount of health information and preventive service we can safely offer the public?

Ten years ago it was considered unethical for a doctor to urge a parent to bring her children to him for protection against diphtheria; today there isn't a doctor in the county who does not urge this protection for every child in his practice. For years the health and medical organizations have been advocating periodic physical examinations; have we not reached the point where the family physician should make personal recommendation for this procedure? At least we can urge periodic pelvic examinations for all women who have borne children. And we shouldn't forget that one woman out of 450 over the age of thirty-five has a cancer of the breast which could probably be cured if detected before it produced symptoms.

MILWAUKEE COUNTY'S MEDICAL RELIEF PROGRAM

Over three years ago Milwaukee County, Wisconsin, abolished its system of salaried physicians for persons on relief, and adopted one which was very similar to that of New Jersey under its E. R. A. system. The service was for home visits only, since hospital care was given in the County General Hospital.

The new system was conducted under an agreement between the members of the County Medical Society and the local relief administration. The patients were permitted to call the physicians of their choice, whose fee was $1.50 for a day call, $2.50 at night, and $20 for an obstetric case.

Ninety-four per cent of the membership of 690 participated in the service. A committee of three members reviewed all disputed bills, and its decisions were respected, although there was some friction at first. There were some cases of abuse of the system by those who could have gone to dispensaries, or were not in need of medical services.

At the end of two years the federal funds were reduced in amount, and the county physicians were again employed to care for those patients who had no choice of physician. But the system is still in effect for those who wish to choose their own physician.

PREVENTIVE PEDIATRICS

By Horton Casparis, M.D., Nashville, Tenn.
From the Department of Pediatrics, Vanderbilt University. Abstracted from the Southern Medical Journal, July, 1937, page 746.

Dr. Casparis discusses conditions which every family doctor meets in his daily practice. His article is especially valuable as an index of the hazards which confront the young child, and of the protective means for which the family doctor is usually the first physician to be consulted.

PRE-CONCEPTIVE AND PRE-NATAL CARE OF MOTHER

Dr. Casparis begins his article with a plea that the family doctor should begin his pre-natal advice to mothers in the pre-conceptive period, thereby preparing a healthy soil in which the seed is to be implanted. Two specific conditions with which the doctor may deal during the pre-conceptive and pre-natal periods are syphilis and poor nutrition.

DEFECTS OF THE NEW-BORN CHILD

The responsibility of the family doctor for the detection of defects of the infant begins immediately after its birth. (By the New Jersey law, the physician in attendance at a birth is charged with the duty of examining the new-born child and reporting its physical defects on a special blank that is provided with the birth certificate. [Editor's Note.—See Journal, August, 1937, p. 531. The State Commission on Crippled Children will aid the family doctor to correct the defects of needy children.])

NUTRITION

Nutrition is a dominant problem in the care of every baby; and cod-liver oil and orange juice, or their equivalents, are necessary for practically every baby. Cereals are to be added at the age of three or four months, and then cooked vegetables; and at the age of ten months the infant is on a childhood diet.

IMMUNIZATIONS

The prevention of specific diseases starts early in the life of the infant. There are four diseases for which immunization is a standard procedure.

SMALLPOX

Smallpox vaccination is to be recommended at the age of three months, for the following reasons:

1. Reactions are less severe than later.
2. The baby lies in his crib, and is not subjected to contamination.
3. The child does not scratch his arm, for he is unable to coördinate his muscular action.
4. The mother is educated to accept other immunizations for the child.

DIPHTHERIA

Dr. Casparis recommends the immunization against diphtheria at the age of six months; and a small dose of the alum-percipitated toxoid as the agent to be used.

The Schick test six weeks later is recommended; and the repetition of the test every year or two until the child goes to school.

WHOOPING COUGH

Dr. Casparis recommends that immunization against whooping cough be given at the age of nine months, but suggests that the doctor explain to the parents what results may be expected from it. (Jour., July, 1937, p. 451.)

TYPHOID AND PARATYPHOID

Immunization with typhoid and para-typhoid is recommended at the age of twelve months, for this is the period when the child puts everything into his mouth and is likely to incur a gastro-intestinal infection.

TUBERCULIN TEST

Dr. Casparis advises that the application of the tuberculin test for school children include those in the pre-school age. He bases his argument on two points:—1, The protection of the children themselves; and 2, as a lead in discovering cases which are spreading the disease.

MENTAL HEALTH

The doctor insists that care of mental health is as important as that of physical health; and says:

"There is in general almost as specific information concerning the prevention of poor mental health as we have concerning the prevention of poor physical health * * *. While the *indications* for building mentally-adequate human beings out of infant material can be made clear, *accomplishment* is difficult, and the methods are not tangible as they so often are in the physical health preventive problem. * * * The mental health problem presents a more serious outlook than does the physi-

cal health problem, since the former is becoming worse every year, in contrast to the gradually improving situation in the physical health problem. This offers a definite challenge to the medical profession to concern itself seriously with the formulation and institution of basic preventive activities is this (mental hygiene) field."

PERIOD OF INTENSIVE PREVENTION

The author believes that the application of preventive measures in pediatrics should begin at birth, rather than the beginning of the school-going period. Before going to school the health of the cihld is the parent's responsibility; but later the parents leave it to the education authorities and mass action, as distinguished from the personal attention of the family doctor. Dr. Casparis says, in regard to public appeals:

"The chief value of any health program lies in what is accomplished *after* the attention is secured; and certainly the most profound or enduring form of education is that resulting from the demonstration of actual accomplishment.

"Has the time not now come for us to begin gradually to push the actual accomplishment back in the earlier years before school, when it is much more valuable to the child and has much greater educational value to the parents?

"It is much more difficult to see that a hundred children scattered around get individual care, than it is to round up a hundred children in one group and do things to them; but the former method is absolutely necessary if we are to build on a firm foundation toward the accomplishment of the best results. It will mean that these children will have to be cared for by practicing physicians; and that many of these physicians will have to recieve more instruction in order to do this work in a fairly satisfactory way.

"Carrying out such procedures will cost time and effort. One of the greatest dangers in the recent trend of public health work has been that of *pauperizing* the recipients of public health benefits. We cheapen the procedures if we do not require either money or effort on the part of the parent."

The author concludes with the suggestion that, if the parents were required to furnish an examination of a child before his entrance in school, they would become concerned with his physical welfare; and also, the physician, realizing his personal responsibility for the examination, will be stimulated to improve the services which he renders.

STUDENT NURSES AND SOCIAL SECURITY TAXES

The Bureau of Legal Medicine and Legislation of the American Medical Association has prepared a statement of the grounds for taxation or exemption of hospitals on account of their student nurses under the provisions of the Social Security Law. This statement is here reproduced from the A. M. A. Journal of August 5, 1937, page 21 B:

"A hospital owned and operated by a corporation or association and claiming exemption from taxation for itself and its employees, under the Social Security Act, because of the charitable, nonprofit-making character of its activities, should establish its tax-exempt status officially as a matter of record in the Bureau of Internal Revenue. To that end it should make application, if it has not already done so, to the collector of internal revenue for the collection district in which the hospital is located, asking for official classification as a tax-exempt corporation or asosciation. Details as to procedure can best be learned by conference with the collector to whom application is to be made."

NEW YORK ACADEMY OF MEDICINE

The Tenth Annual Graduate Fortnight of the New York Academy of Medicine will be held from November 1 to 12, 1937. The general subject will be "The Urinary Tract,—Its Medical and Surgical Disorders".

There will be thirty-six clinics, held in twenty-five hospitals, by 222 demonstrators.

Ten evenings will be devoted to evening sessions in the auditorium of the Academy of Medicine, at which twenty-eight speakers are listed.

A scientific exhibit in the Academy of Medicine will be open throughout the Fortnight, and will be in charge of Dr. Harrison S. Martland, of Newark, N. J. Practically every phase of the subject of kidney lesions will be demonstrated by pathological specimens, charts, x-rays, and literature.

A registration fee of three dollars will admit a physician to every feature of the Fortnight. For information, address The New York Academy of Medicine, 2 East 103rd Street, New York, N. Y.

CONTACTS AND COMMENTS

The August issue of the Bulletin of the Essex County Medical Society is the initial number of the periodical in its proposed enlarged form. It contains twelve pages, five of which are devoted to a list of the officers and committees of the Essex County Medical Society. There are forty-one committees, containing about 600 names. Allowing for duplication of names, about 70 per cent of the membership are enrolled in assignments to definite activities, thereby giving the great majority of the members a particular responsibility in medical administration. Reading the eight pages of the abstracts of the annual reports of the committees in the Journal of June, 1937, will confirm the reputation which Essex has for being a "Society at work".

This issue of The Journal, page 578, contains the first installment of the surveys of the medical services in the several counties, as authorized by the House of Delegates. (Annual report of the Publication Committee, Journal, April, 1937, p. 233, and the Transactions, p. 64.) Hunterdon County, the subject of the first survey, was a fortunate choice, for a careful study of its conditions revealed the possibilities of accomplishment through the spontaneous activities of the medical profession, without the spur of lay agencies. Read the editorial on page 543.

Burlington County in its early days is credited with having an ash tree in whose cleft hernia patients used to sit, in the belief that a cure would thereby be effected.

Burlington County is also credited with having another tree through whose cleft rachitic babies were passed for therapeutic purposes. A picture of this procedure is shown in an advertisement of cod-liver oil in the inside back cover of The Journal of January, 1937.

Can any medical historian supply information or tradition regarding the former practice of this procedure in New Jersey?

County Medical Societies are likely to develop along numerous lines, and even State Medical Societies may become provincial in their outlook. An important function of the Journal of a State Medical Society is to record the trends of the activities of groups of physicians under conditions that are different from those in its own circle of influence.

The Journal of The Medical Society of New Jersey is limited in size, and cannot find room to reprint a tithe of the good things that are found in other medical journals. However, the summer lull in Medical Society activities has afforded an opportunity to introduce the new department called "Opinions and Plans," which is initiated on page 582. The five articles that are reprinted will have a practical value to the physicians of New Jersey.

The New Jersey State Commission for Crippled Children is reporting the original work that has been conducted in the Vineland institution in the training of adolescents who are afflicted with birth palsies. The excellent results of training a class of fifteen children, published on page 552, is an encouragement to all practitioners of medicine.

Physicians are familiar with the striking results of muscle training in poliomyelitis, in which the lesson is in the nerve cells of the spinal cord. Dr .Phelps, of the Vineland institution, is demonstrating excellent results from similar muscle training in those children in whom the lesion is principally in the nerve cells of the motor area of the brain. If a few nerve cells remain, they seem to be able to take on new functions under persistent training.

Dr. Phelps also points out the great improvement in the social behavior of those children who learn to walk and to do other acts that are dependent on the functioning of even a few cells of the motor area of the brain.

The principles of the modern treatment of severe burns are well set forth in the article by Dr. Holters, on page 545. The doctor warns against the use of oily preparations in severe burns, explaining that they prevent the action of the tannic acid accepted as the essential ingredient in the scientific treatment of severe burns. In the light of modern experience, the handbooks of first aid will have to be radically revised.

Following the example set in 1934, this September issue of the Journal contains a table of the dates of the 149 regular meetings of the County Medical Societies of New Jersey. Each

meeting is of interest to the members of other county societies, and is of special value to the officers and committeemen of the State Society. As in previous years, a supply of the list is reprinted on cardboard, and is avaliable to those who desire to make use of them. Make your applications to the Executive Officer in the headquarters of the State Society.

It is important that the Executive Officer shall maintain an accurate list of all physicians of New Jersey regardless of their membership in the county societies. This list is the basis of the roster of physicians in the Tri-State Directory of the medical men of New Jersey, New York, and Connecticut. Equally important with the list of members is the record of their hospital connections.

The list is constantly undergoing changes. For example, about ten per cent of the physicians of New Jersey change their office addresses during the year. The list is kept up to date so far as possible by utilizing every available source of information. But as a final check, a card is mailed to every known physician. The response is about as follows:

One-half respond within a few days.

One-half of the remainder respond within a month or two.

One-half of those still remaining respond to a second request for information.

This leaves about 15 per cent still to be accounted for. It may be necessary that the Secretaries and Treasurers of county societies shall be asked to supply the missing names.

Attention is called to the article on maternal mortality rates on page 565, and to the editorial on page 542. While it is true that the rates in New Jersey are lower than those in some of the other States, yet the rates are still too high and can be cut in half by the action of physicians themselves. Every physician in New Jersey has a personal responsibility in this respect. Even if he does not practice obstetrics, he can be active in promoting the plans of the Maternal Welfare Committees of the State and County Societies.

Education of prospective mothers is an important measure in lowering the mortality.

Early diagnosis and treatment of pre-cancerous conditions is essential in reducing the mortality from that disease. This is of increasing importance in view of the constantly increasing proportion of people who reach the cancerous age.

An essential procedure in the campaign against cancer is the substitution of a feeling of hope among that large proportion of persons whom fear prevents from consulting a physician. The Passaic County Medical Society is setting an excellent example to other counties in planning a "Cancer Exhibit", with the object of educating the people and removing their unreasoning fear of the disease. See the announcement on page 589.

PERSONALS

Dr. Thomas K. Lewis, Chairman of the Board of Trustees, has been in Cooper Hospital, Camden, where he was taken early in August with an attack of severe precordial pain, associated with abdominal symptoms. He is now free from pain, but his medical advisers are prescribing complete physical rest for an indefinite period. Dr. Lewis and his family have taken a cottage at Medford Lakes, N. J., where at last reports he is recuperating satisfactorily.

President and Mrs. Herrman are in Portland, Maine, in order to be near their sixteen-year-old son, William Jr., who had developed acute appendicitis on August 5, while at a summer camp where medical service was not available. He was taken forty miles to Portland, Maine, where an emergency operation was done several hours after the onset of his sickness. A gangrenous appendix and a peritoneal abscess were found. On August 29, a second operation was done for peritoneal abscess.

Dr. Herrman, writing on August 30, said that it would be necessary for him to remain in Portland until his son is out of danger.

Dr. Elias J. Marsh, Treasurer of The Medical Society of New Jersey, has been in the hospital for a month under observation for an abdominal condition.

THE PATERSON CANCER WEEK

The Passaic County Medical Society will hold a "Cancer Week" in Paterson from Monday to Friday, October 11 to 15, 1937.

Afternoon events will be held in the Paterson Free Public Library, 250 Broadway, Paterson, with the following features:

Daily, 2 to 6 p. m., a popular exhibit on cancer, and one for physicians, including talking movies.

Lectures at 4 p. m.

Monday—The Nurse and the Cancer Problem—Dr. L. G. Shapiro, Paterson.

Tuesday—Cancer of the Stomach—Dr. Norman T. Dingman, Paterson.

Wednesday—Nursing Care of the Cancer Patient—Dr. William Spickers, Paterson.

Thursday, Cancer of the Colon and Rectum—Dr. William Spickers, Paterson.

On Wednesday, Thursday, and Friday, evening sessions will be held in the Central High School. On Wednesday the subject of "Cancer of the Stomach" will be presented by three physicians from the General Memorial Hospital, New York,—Dr. F. T. Stewart, Pathologist; Dr. Ralph Herendeen, X-rayist; and Dr. G. T. Pack, Surgeon.

On Thursday evening, Dr. Frank E. Adair, Surgeon at the Memorial Hospital, will address the public on "The Cancer Problem".

On Friday evening, a symposium on "Cancer of the Colon" will be conducted by Dr. Paul Klemperer, Pathologist, Mt. Sinai Hospital, New York, and Dr. F. H. Lahey, Boston.

Physicians from any part of New Jersey will be cordially welcomed.

LIST OF PHYSICIANS DYING IN NEW JERSEY IN JUNE AND JULY, 1937

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Roderick Byington	64	June 2, 1937	Summit	Same	Cerebral thrombosis.
Frank M. Child	67	June 21, 1937	Teaneck	Same	Chronic myocarditis.
St. Elmo Davenport	64	June 28, 1937	Atlantic City	Same	Mitral regurgitation.
Herbert W. Long	65	June 10, 1937	St. Michael's Hosp., Newark	Irvington	Cerebral embolism.
Horace Bowen	70	July 13, 1937	Nursing Home, Montclair	Montclair	Arterio sclerosis. Chronic nephritis.
Harriet E. B. Holmes	67	July 25, 1937	Nursing Home, Oakland	Pequannock	Arterio sclerosis.
Emory Richie	48	July 21, 1937	Hackensack Hospital	Hackensack	Arterio sclerosis.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS FOR JULY, 1937

County	Diphtheria Toxoid	Smallpox Vaccinations	County	Diphtheria Toxoid	Smallpox Vaccinations
Atlantic	1	1	Monmouth	244	318
Bergen	101	348	Morris	66	16
Burlington	9	9	Ocean	21	0
Camden	40	26	Passaic	312	234
Cape May	2	4	Salem	8	14
Cumberland	13	37	Somerset	234	229
Essex	334	426	Sussex	0	0
Gloucester	67	89	Union	108	193
Hudson	4	3	Warren	36	57
Hunterdon	0	3			
Mercer	5	1	Totals	1656	2046
Middlesex	51	38			

DATES OF MEETINGS OF
County Medical Societies of New Jersey
SEPTEMBER, 1937 — JULY, 1938

SEPTEMBER, 1937

9	Burlington
9	Passaic
14	Bergen
15	Middlesex
16	Gloucester
	Sussex (at call of President)

OCTOBER, 1937

5	Camden
5	Cape May
5	Hudson
8	Atlantic
8	Salem
12	Bergen
12	Cumberland
13	Mercer
13	Ocean
13	Union
14	Burlington
14	Essex
14	Passaic
19	Warren
20	Middlesex
21	Gloucester (Social Session)
21	Morris
26	Hunterdon
27	Monmouth

NOVEMBER, 1937

2	Camden
2	Hudson
9	Bergen
10	Mercer (Banquet)
10	Ocean
11	Burlington
11	Essex
11	Passaic
12	Atlantic
17	Middlesex
18	Gloucester
18	Morris
24	Monmouth
	Sussex (at call of President)

DECEMBER, 1937

7	Hudson
7	Camden
8	Mercer
8	Ocean
8	Union
9	Burlington
9	Essex
9	Passaic
9	Somerset
10	Atlantic
10	Salem
14	Bergen
14	Cumberland
15	Middlesex
16	Gloucester
16	Morris
22	Monmouth

JANUARY, 1938

4	Camden
4	Hudson
11	Bergen
12	Mercer
12	Ocean
13	Burlington
13	Essex
13	Passaic
14	Atlantic
18	Warren
19	Middlesex
20	Gloucester
20	Morris
25	Hunterdon
26	Monmouth
	Sussex (at call of President)

FEBRUARY, 1938

1	Camden
1	Hudson
8	Bergen
8	Cumberland
9	Mercer
9	Ocean
9	Union
10	Burlington
10	Essex
10	Passaic
10	Somerset
11	Atlantic
11	Salem
16	Middlesex
17	Gloucester
17	Morris
23	Monmouth

MARCH, 1938

1	Camden
1	Hudson
8	Bergen
9	Mercer
9	Ocean
10	Burlington
10	Essex
10	Passaic
11	Atlantic
16	Middlesex
17	Morris
17	Gloucester
23	Monmouth
	Sussex (at call of President)

APRIL, 1938

5	Camden
5	Cape May
5	Hudson
8	Atlantic
8	Salem
12	Bergen
12	Cumberland
13	Mercer
13	Ocean
13	Union
14	Burlington
14	Essex
14	Passaic
14	Somerset
19	Warren
20	Middlesex
21	Gloucester
21	Morris
26	Hunterdon
27	Monmouth

MAY, 1938

3	Camden
3	Hudson
10	Bergen
10	Sussex
11	Mercer
11	Ocean
12	Burlington
12	Essex
12	Passaic
13	Atlantic
18	Middlesex
19	Gloucester
19	Morris
25	Monmouth
	Salem (Social Meeting)

JUNE, 1938

8	Mercer
9	Somerset
14	Bergen
14	Cumberland
15	Middlesex
16	Morris
22	Monmouth
	Camden (Outing Meeting)

JULY, 1938

19	Warren
26	Hunterdon

Cape May has two other meetings at the call of the President.



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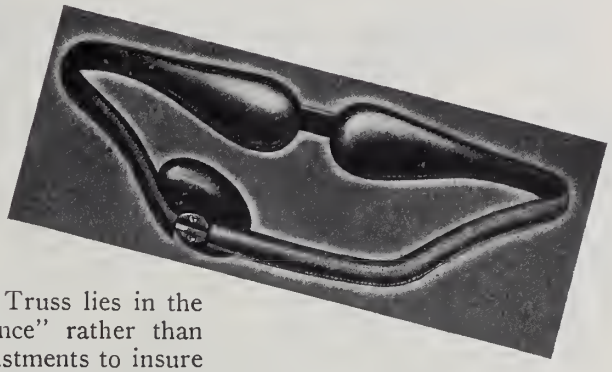
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Manganese (Mn)	None	None
Calcium (Ca)	13.7	0.80
Magnesium (Mg)	5.8	0.34
Sodium (Na)	5.6	0.33
Potassium (K)	Trace	Trace
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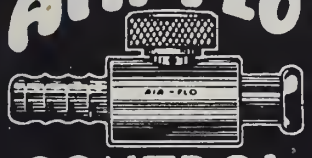
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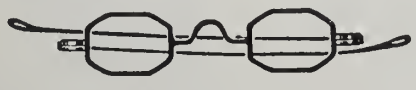
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MONTCLAIR	Upper Montclair Pharmacy, 629 Valley Rd.	MOntclair 2-1665
EAST ORANGE	Clinton Pharmacy, 481 Central Ave.	ORange 5-6868
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BLOOMFIELD	Nicholas G. Burgess, 50 Broad St.	BLoomfield 2-1006
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WEST ORANGE	Tully's Drug Store, 298 Main St.	ORange 3-9521
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ORANGE	Mosler's Pharmacy, 268 Main St.	ORange 3-1029
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Gentlemen:

Please send me complete details:

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At the first suspicion of pneumonia—

TYPE IT!

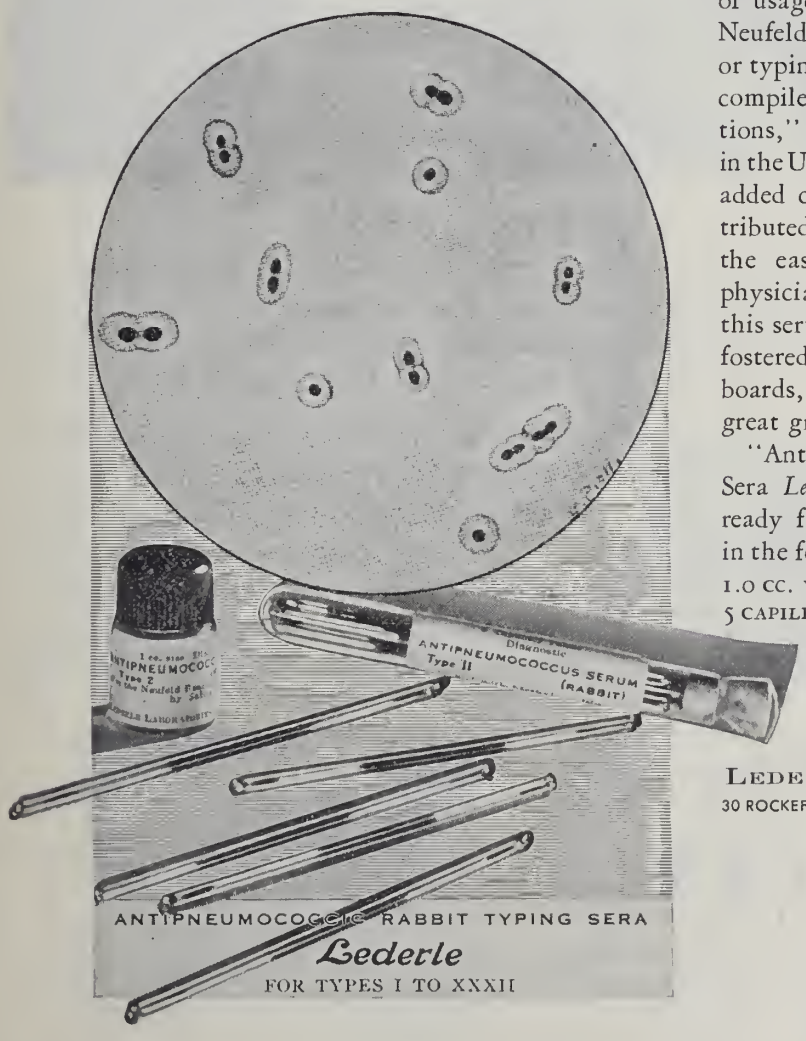
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5 CAPILLARY TUBES FOR INDIVIDUAL TESTS



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Acute Rhinitis in Children



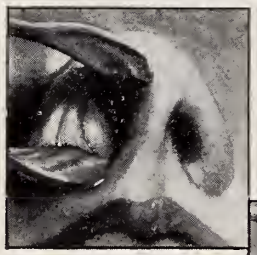




FIG. 1. J. M. C. White, female, age 4. June 5, 1936. Acute rhinitis. 11:40 A.M. Two inhalations of 'Benzedrine Inhaler'.

FIG. 2. 11:50 A. M. Maximum shrinkage evident.

In 100 cases of acute rhinitis in children from two months to twelve years of age treated with 'Benzedrine Inhaler' Scarano and Coppolino report prompt and adequate shrinkage of the nasal mucosa in 97 per cent. — Arch. Pediat. **54**:97, 1937.

The vapor form — in addition to its greater effectiveness — overcomes the strenuous objections which children show to liquid inhalants as applied by drops, tampons or sprays. Obviously, however, as with any medication for children, an adult should supervise the use of the Inhaler and retain possession of the tube.

BENZEDRINE INHALER

A VOLATILE VASOCONSTRICTOR

ACCEPTED AMERICAN MEDICAL ASSN.



Each tube is packed with benzyl methyl carbinamine, S.K.F., 0.325 gm.; oil of lavender, 0.097 gm.; and menthol, 0.032gm. 'Benzedrine' is the trade mark for S.K.F.'s nasal inhaler and for their brand of the substance whose descriptive name is benzyl methyl carbinamine.

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INTRAVENOUS SOLUTIONS IN VACOLITERS



They're the finest that we know how to make

When the operation's done, they've wheeled your patient away . . . when little doubts and fears keep querulously asking, wondering . . . there's *one* that won't trouble you.

Granted you needed and used an intravenous solution, granted that you specified Baxter's in Vacoliters . . . *we* think you'll feel a sense of security knowing that BAXTER'S will do *its* part.

Baxter's . . . in Vacoliters . . . will do its part because all it has to do has been planned and made sure, so that it *will* do the helpful healing task you use it for.

It is *sterile*, as sterile as that word means . . . *your* patient will not be in danger. It is *stable* and the solution you think you've injected *is* the solution you *have* injected. You can have peace of mind there, too.

In medicine and in surgery there are a few fine things that have no counterpart. Solely by right of their quality they stand apart from their kind to give you peace of mind, a surety in action and a certainty that is incomparable.

These are descriptive of Baxter's Intravenous Solutions in Vacoliters. They give you peace of mind . . . are the finest that we know how to make.

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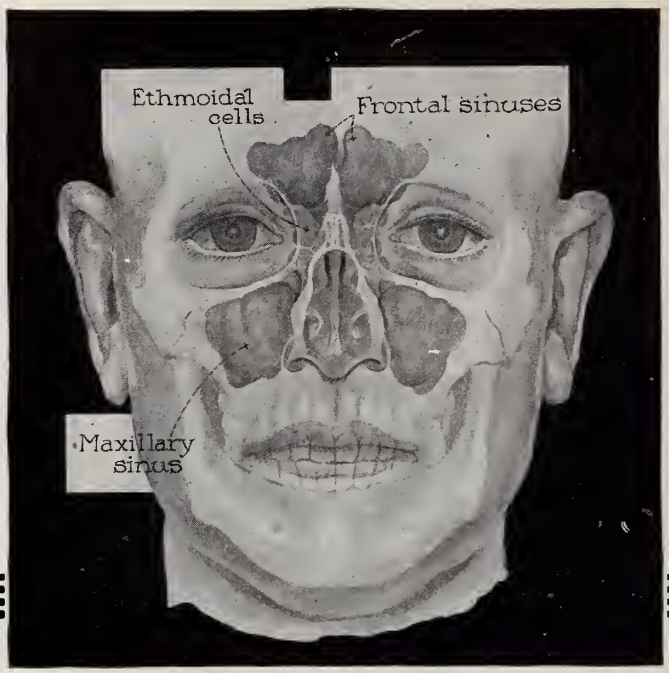
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Improved Nasal Ventilation and Drainage

Accomplished With

NEO-SYNEPHRIN

HYDROCHLORIDE

(levo-meta-methylaminoethanolphenol hydrochloride)

Relief of the distressing nasal congestion of rhinitis and associated conditions is accomplished promptly and comfortably by the application of Neo-Synephrin Hydrochloride by dropper, spray or nasal pack.

NEO-SYNEPHRIN HYDROCHLORIDE

does not sting on application, is relatively stable, and is less toxic in therapeutic dosage than epinephrine or ephedrine.

Supplied in 3 Forms:

NEO-SYNEPHRIN HYDROCHLORIDE EMULSION

¼% (1-oz. bottle with dropper)

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NEO-SYNEPHRIN HYDROCHLORIDE SOLUTION

¼% for dropper or spray
1% for resistant cases } (1-oz. bottle)

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NEO-SYNEPHRIN HYDROCHLORIDE JELLY

½% (in collapsible tubes with applicator)

FREDERICK STEARNS & COMPANY

DETROIT NEW YORK KANSAS CITY SAN FRANCISCO
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CANNED FOODS IN THE CONTROL OF LATENT AVITAMINOSES

● In June, 1935, this space was devoted to a discussion of some of the general aspects of latent avitaminoses. It appears pertinent to report some of the more recent ideas in regard to this important field.

Considering the subject of avitaminoses in its entirety, the modern medical attitude is aptly expressed by the following statement: "... the mild or latent forms of the vitamin deficiencies are more important in practice at present than the fully developed cases. The latter are uncommon, are easily recognized and are usually promptly and adequately treated. On the other hand there is reason to believe that minimal or mild forms of these diseases are much more frequent, often escape recognition and, because of their insidious effect on large numbers of people, constitute a more serious problem than the occasional advanced cases." (1)

Consideration of this statement brings home the importance of optimum vitamin intake. Students of nutrition agree that in order to achieve this objective, a liberal and varied diet must be available. The constituents of the diet should be wholesome foods, the preparation of which has not materially reduced their intrinsic nutritive values. Commercially canned foods fall well within this classification.

Modern canning procedures are designed to protect the vitamin potencies of the food. Recent reports in the scientific literature indicate the success attained in retaining vitamin values in commercially canned foods. (2)

In general, the control of latent avitaminoses and the advancement of positive health appear to be largely matters of practical application of facts made available by the modern science of nutrition. We wish to direct attention to the part which the wide variety of canned foods available on the American market may play in establishing dietary regimes calculated to control the avitaminoses.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) 1937. J. Am. Med. Assn. 108, 15.
(2) 1936. J. Nutr. 12, 405.
(2) 1936. J. Am. Diet. Assn. 12, 231.
1936. J. Nutri. 11, 383.
1936. Ind. Eng. Chem. 28, 1009.
(2) 1935. J. Home Econ. 27, 658.
1935. U. S. Pub. Health Rpts. 50, 1333.
1935. Am. J. Pub. Health 25, 1340.

This is the twenty-ninth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

GETTING MORE OUT OF THE COW THAN JUST MILK



She Gets Her Breakfast In Bed All Year 'Round. Walker-Gordon cows never have to go nosing around a pasture for food, perhaps eating something which would produce less than perfect milk. They have brought to them, every meal, the richest, finest food that science and Nature can together produce. A reason why Walker-Gordon Certified Milk always has higher nutritive value.



Imitation of a Calf—These automatic milkers, used by Walker-Gordon at Plainsboro, N. J., are a close mechanical reproduction of a calf in their milking action. So, they are gentler, more humane than any human hands at their work—cleaner, too, because they are sterilized between use on each cow. An instance of the more scientific certified milk production methods employed by Walker-Gordon.

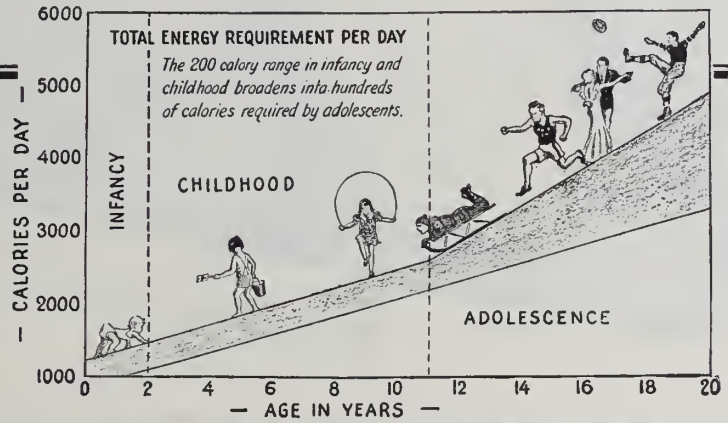


No Humans Get Such Medical Care—What man or woman that you know gets expert twenty-four-hour-a-day medical attention? The selected cows that produce Walker-Gordon Certified Milk *do*—Walker-Gordon's specially qualified veterinary staff is busy *keeping* them fit and healthy all around the clock, all around the calendar, all through their lives. A reason why Walker-Gordon is the *safest* of milks.



The price of Walker-Gordon Certified—the milk made especially for children from nine months before birth to nine years after—is much lower than it used to be, only a few pennies more than that of grade A milk . . . perhaps the cost of a newspaper.

Careful study shows many young folks do not consume enough food to provide them with the enormous energy requirements necessary during the transitional period of adolescence. The symptoms are the consequence of undernutrition.



Normal adolescent boys and girls frequently complain of fatigue. They feel weak and irritable; they show a diminished ability to concentrate; they are disinclined to work; they are physically inefficient.

Some of these symptoms are physiological manifestations of adolescent development.

The graph reveals the sudden rise in caloric requirement during adolescence. Three hurried meals are usually insufficient to provide the tremendous caloric needs. Accessory meals, mid-morning and mid-afternoon, in certain instances, may be prescribed with advantage.

And Karo added to foods and fluids can increase calories as needed. A tablespoon of Karo yields 60 calories. It consists of palatable dextrins, maltose and dextrose (with a small percentage of sucrose added for flavor).

Karo is well-tolerated, highly digestible, not readily fermentable, effectively utilized and inexpensive.

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★ **Infant feeding practice is primarily the concern of the physician, therefore, Karo for infant feeding is advertised to the Medical Profession exclusively.**



NEW! A valuable Heinz-made soup combining carefully-selected lean beef, chicken livers, young beef livers and choicest vegetables! Especially rich in vitamins A, B, and G. Recommended for anemic infants and adults.

WHY HEINZ-MADE MEANS BEST MADE

STRAINED foods made by Heinz originate in a division of the *same famous kitchens* where for more than sixty-nine years the "57 Varieties" have been produced.

And the same *quality tradition* that has characterized all of Heinz efforts is firmly adhered to in the production of these victuals for infants and invalids.

Only The Best Ingredients

Only the finest of choice fruits, vegetables and other ingredients are used after careful selection by trained experts.

Every step in the special, dry-steam processing of Heinz Strained Foods calls for the fullest possible retention of vitamins, mineral salts and nutrients.

Greatest Name In Food

You can rely on the same margin of safety in Heinz Strained Foods that you demand in drugs. And remember, too, they bear *both* the Seal of Acceptance of the American Medical Association's Council on Foods—and the greatest name in the food industry!

HEINZ STRAINED FOODS

12 KINDS—1. Beef and Liver Soup. 2. Strained Vegetable Soup. 3. Mixed Greens. 4. Spinach. 5. Carrots. 6. Beets. 7. Peas. 8. Prunes. 9. Cereal. 10. Apricots and Apple Sauce. 11. Tomatoes. 12. Green Beans.

57 ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods



CRUSADING

SINCE

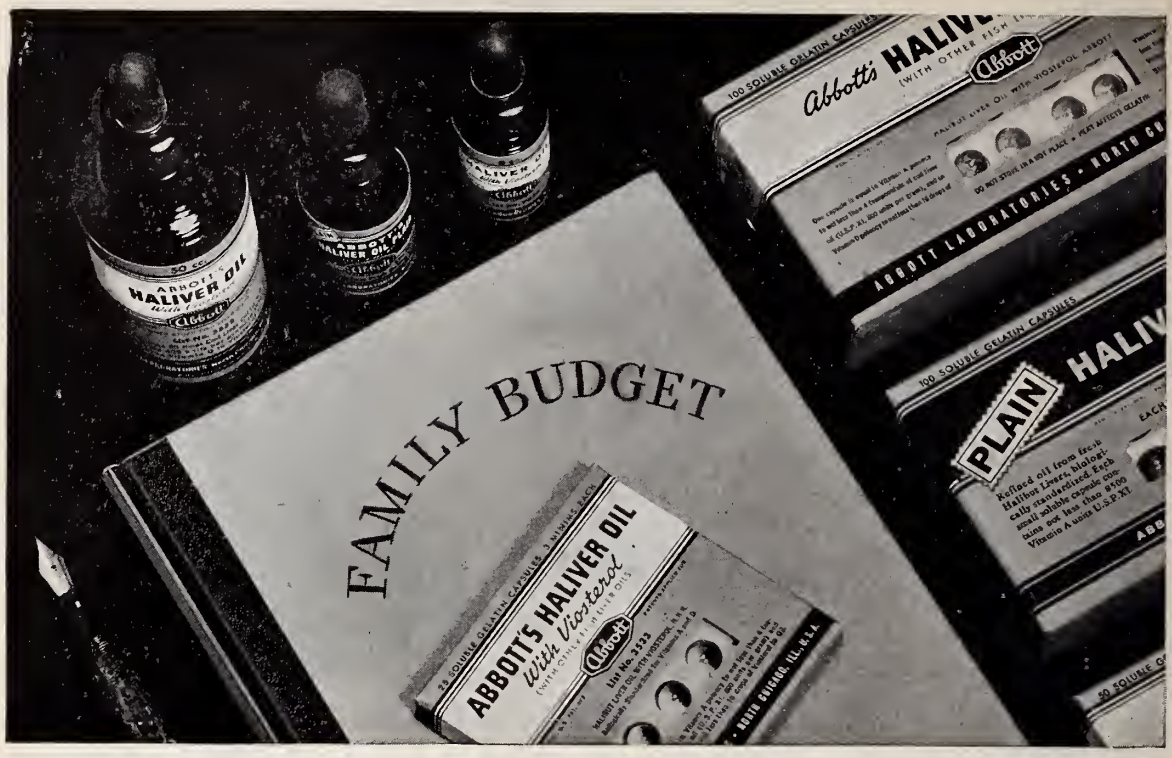
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Twenty-seven years ago we began the ethical manufacture of pharmaceuticals. Through the years our scientists have been ever alert in the search and discovery of medicines that would alleviate the suffering of mankind and be of value to physicians in their fight against pain and disease.

Today we manufacture more than one thousand items . . . four hundred of them our exclusive formulae. Because many of these are of outstanding prominence, thousands of doctors prescribe them regularly.

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"Price differences"

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EDITORIALS

The Medical Fraternity

The medical profession is composed of men of varied gifts and abilities, and of diverse temperaments and social adjustments; but the characteristic that is common to practically all physicians is their fraternal spirit. The few who lack that trait show social abnormalities which are evident to people generally as well as their professional colleagues.

The sense of fraternalism is a natural result of the doctor's contact with human suffering,—mental as well as physical. The years of self-discipline to which every physician subjects himself are universally interpreted as his initiation with a fraternity whose secrets are beyond understanding by all other mortals. The physician's consciousness that he alone possesses a high degree of knowledge of the hidden processes of life is a driving force which impels him to go to the relief of every afflicted person to whom he is called to minister. To the doctor, every sufferer is a brother in need to whom he gives his service, even at the sacrifice of his own comfort.

The full realization of the breadth and depth of the fraternal bonds of medicine comes to the physician when he or a loved one is a patient in grave need of the comforting presence of a chosen colleague. President Herrman has felt impelled to express his appreciation of that fraternity as exemplified in the self-sacrificing service rendered to his son by brother practitioners. (Jour., Sept., page 540.)

Paying the Freight

I spent the Huckleberry Finn days of my boyhood in a small town in New York State. In that town we had two doctors, a couple of lawyers, a civil engineer, a teacher, and several ministers representing the professions. There was a local tailor who made most of the men's clothes, and a cobbler who, in addition to repairing shoes, made many boots and shoes by hand. The local grocer was independent and not a member of a chain. He was a friend and neighbor of everyone. While there were some canned goods on his shelves, there were more home-canned vegetables and fruits made by local farmers' wives. The local butcher would

often send word to his favorite patrons when he had a side of beef from a local farmer who was known to have good stock. It was a day of individualism. It was a time when an automobile on the road attracted nearly as much attention as the airship Von Graf Zeppelin or the Hindenberg. In fact, it was a typical rural community in the mauve decade of the so-called gay nineties.

The principal doctor in town knew everybody and his economic status. There were no free clinics. There were no welfare organizations either coöperating or competing with the local medical men. In fact, there was no nearby hospital. Many operations in the community were performed on kitchen or dining room tables. In such cases the doctor was the anesthetist, the operator, and the chief assistant.

Great changes have taken place in the life of such a community since then. The independent grocer has almost, if not entirely, disappeared. The chain stores and managers thereof have taken his place. An independent grocer to keep alive today must be a member of a chain and buy his groceries at a wholesale minimum. The goods canned by local farmers' wives have disappeared from his shelves. The local tailor is largely a repairer and presser. The cobbler is now merely a repair man; the making of shoes has become entirely a factory process. The independent civil engineer has disappeared; he is now employed by an engineering firm. The private teacher or tutor has disappeared largely because of the increase in the facilities of district high schools to teach all subjects. Very little barnyard surgery is now indulged in, because with the coming of good roads and automobiles there is hardly a rural community that is not within reach of a good hospital.

In the days of which I am speaking, the measure of wealth of the average family was whether or no it had a piano. Very few families who lived in town owned a horse and buggy unless it was necessary to the business of the head of the family. The piano has ceased to be a measure of economic status; the radio and the victrola have taken its place, and the vehicle of conveyance is no longer a luxury because everyone can now own some type of automobile. Modern industry, the result of the machine age, and intense coöperation and integration of human effort have made many things that were once luxuries now everyday necessities, and has produced such things as the radio, which in the days of which I am speaking was not even dreamed.

Medical care today compared to then has improved by leaps and bounds. There has been vast improvement in diagnostic measures. There has been a great increase in the number of hospitals, and a raising of the standard of hospital care. The training necessary to produce modern, competent physicians has practically doubled. While the cost today of a good pair of shoes, of a well-made suit of clothes, of automobiles and other articles essential to modern life, has decreased, the quality has gone steadily upward.

The quality of medical care has also gone steadily upward, but so has the cost. I personally can see no way of reducing the present cost of such medical care, because it is so largely built upon individual service and effort of several doctors and nurses and the use of costly equipment, whereas in the gay nineties even an operation was largely a one-man proposition. These people are all highly trained and are entitled to a remuneration for their service commensurate with their training and their ability. In many cases the services of such people are essential to the preservation of life.

Modern industry, through the use of machinery, integration of effort, rapid transportation and a large sales force, has been able to reduce both the cost and the selling price of the article sold. There is no way in which proper medical care can be so given. How then can we expect the average family to be able to purchase modern medical care?

A recent catastrophic illness in my own family has brought this problem before me very vividly. I can easily see how a family of modest income would be completely floored by an illness where such medical care as we have in mind is necessary. If they were able to pay the hospital and nurses' bills, there would be nothing left for the doctor. In many cases

they would be unable to meet the hospital and nurses' bills, and would be dependent upon charity.

If we are unable to reduce the cost of necessary medical care, we must give thought to spreading this cost either over a period of time or among a large number of people; otherwise we as physicians shall continue to treat more and more people for nothing, or be forced to become employees of large institutions where medical care is given on a factory basis, or as Senator J. Hamilton Lewis said, "We shall become instruments of government."

The only answer that seems possible to me involves the insurance principle. Every home owner who is worthy is sold on insurance as a protection against fire. Certainly the health of his family is of as much importance as the preservation of the equity in his home. I believe that the medical profession must give serious consideration toward stimulating the interest of patients in hospital insurance, so that in the event of a catastrophic illness the major portion of their expenses will be taken care of without hardship. Under such conditions the physician who gives his time and energy toward the medical care of the patient will have some chance of being remunerated, because the very necessary hospital and nurse expense will not completely drain the family pocketbook. Hospital insurance is not new, as you know. There are many groups already organized, but, so far as I have been able to observe, the profession has either been lukewarm toward the plan, or has damned it with faint praise.

If physicians were to become interested in hospital insurance from the standpoint of selling it to patients, we would be better able to correct those things which we criticize in hospital insurance, because any business man will tell you that no one has more influence with management than the successful salesman. Were we therefore to actively interest ourselves in selling hospital insurance, we would have the right, and would be welcomed by the hospital groups, in helping to formulate the policies of these groups.

I believe the answer to the threat of state medicine and compulsory health insurance can be found by the medical profession itself through the promotion of *voluntary* hospital insurance supervised by County Medical Societies. All forms of compulsion, prohibition, and paternalism should be reserved for the enemies and wards of society. Society—meaning the self-respecting, self-supporting free-men members of the community—forms the government, not the government, society.

W. G. HERRMAN.

Home Missionaries in Medicine

No good cause succeeds until it is well understood, and is approved and supported by a large number of people. The ways and means by which converts and support are obtained are many and varied, but the principle is always the same. This principle is called by many names,—education, publicity, promotion, salesmanship, and advertising; but its essential factor is sound information, repeated frequently and persistently, over an adequate period of time, by a large number of well-chosen "disciples".

General practitioners of medicine are united and organized in adopting and exemplifying high standards of *scientific medicine* which are developed and formulated by their leaders. The development and adoption of equally high standards of the *distribution* of those scientific services is now engaging the serious attention of leaders in medical societies; but at the present time the adoption of those standards by practitioners is entirely voluntary.

The people's acceptance of early diagnoses, and of immunizations, will depend in a very large measure upon the attitude of their family doctors. Medical men who neglect to actively try out the tentative plans recommended by the leaders of the organized profession, or who talk against these plans but offer none

better, are usually those who complain most bitterly about changes and new developments.

The State and county society officers and committeemen are earnest and hard workers in the interests of their profession and their colleagues. They deserve not only verbal approval, but the active support of helpers with a "missionary" spirit who will "educate" first *our own colleagues* and then the *public* regarding the services which we offer for the purpose of preventing as well as curing disease and defects.

Are you doing *your* full share as a member of The Medical Society of New Jersey? Do you understand the form of organization, the procedures, and the plans of your State and county medical society? These points have been fully set forth in the current issues of your Journal.

Do you know how the Welfare Committee of the State Society functions through its four sub-committees, and its sixteen advisory committees? Read the answer in The Journal of August, 1937, page 521.

Do you know of the active contacts which the State Society maintains with other organizations? Read the list in The Journal of May, 1936, page 256.

Do you know this year's program and plans of your State and County Medical Society? Read The Journal of August, 1937, page 520.

Have you read your copy of the Handbook of Preventive Procedures that was issued as a supplement to The Journal of March, 1937? There you will find practical information regarding the services which you can render in prevention, early diagnosis, and treatment; and also the help which you can obtain from organizations both official and voluntary.

LeRoy A. Wilkes.

Appreciation of Medical Services

It is commonplace for the tired doctor to leave an evening engagement and drive for miles through pelting sleet and muddy roads to minister to dire human need without consideration of fee or reward; and all attempts to capitalize his heroism have been repudiated by the people themselves, for these measures depict the physician as a serene super-man, untouched by the intense confusion and despair of the stricken family.

The doctor, responding to a grave emergency, renders a two-fold service. Not only does he dispense medical and surgical services which seem miraculous; but his very presence is a benediction, although it be expressed in terms of stern rebuke, and grim orders in arousing the hysterical members of the despondent family to give him emergency help and assistance of a kind from which they would shrink in ordinary occasions.

The ministering doctor should of course present a bill commensurate with the financial resources of the patient; but its payment discharges only one-half of the obligation—that for his *scientific* knowledge and skill. There still remains due a tangible recognition of the doctor's *benedictory* services. This debt is best discharged by a gift to a worthy charity or church which shall ever be a holy reminder of the services of the doctor. A formal gift within the means of the patient, however small it may be, will win the commendation of the Great Physician, who is recorded by St. Luke, a physician, to have said of the poor widow giving the smallest of coins to the Temple treasury, "She hath done what she could."

Cross References

The members of the Executive Staff of The Medical Society of New Jersey, like those of other States, make a practice of reading the Journal of the American Medical Association, and the Journals of the other State Societies, for the purpose of discovering projects and methods which they can put to practical use. It is the custom of The Journal of The Medi-

cal Society of New Jersey to print the date of issue and the page of the Journal from which a reference is taken.

It is the common custom of State Journals to quote from another Journal, with the statement that it is from "a recent issue", or to append the name of the Journal without giving its date of issue or the page. These quotations are of great value to the officers, for they often reveal important articles which they have missed in their own reading, and whose sources are often difficult to trace. An example is a reference which a State Journal made to the report of the survey of chronic diseases now being made by the U. S. P. H. S., which the article said could be found "in a recent number of the Journal of the American Medical Association". A search of three hours through the files of the A. M. A. Journal failed to disclose the article, until finally it was discovered under a title which did not reveal its scope. A half line giving the date and page of the reference would have been sufficient to enable a reader to turn to the article at once.

Nearly every page of the Journal of the A. M. A. contains references to the source of its quotations. Its example is an excellent one for every State Journal to follow.

Preparation for U. S. P. H. S. Positions

The United States Civil Service Commission announces an examination to be held for the positions of Associate Medical Officer in the U. S. Public Health Service at a salary of $3200 a year, or less if quarters and rations are furnished. An undesirable feature of the position is that applicants must have graduated from a class A medical school not more than seven years prior to May 1, 1937. A candidate will be eligible for the position if he has had one year of general interneship; and also one year of practice in some specialty of the service, either as an interne or assistant in a hospital or in private practice in that specialty.

Two years of interneship will fit a candidate to serve in a government hospital, but it will not fit him to do work in the field as an investigator of conditions in which private practitioners are involved. One of the criticisms of the contacts of field investigators with practicing physicians is that the officers do not have the point of view of the family doctor or the local specialist, in dealing with private patients.

A suggestion—possibly impractical—is that an accepted candidate shall be required to spend the first year of his service as the assistant of a physician in private practice. There are local doctors who will be glad to avail themselves of the free services of a capable young doctor, provided they are assured that the appointee will not become his competitor. The assistantship will be of value to both parties.

Another suggestion is that the appointee might spend a year as assistant to the Secretary or the Executive Officer of the Medical Society of a State, or a large county. In fact, the U. S. P. H. S. could not spend its money to better advantage than by providing the Medical Society with an assistant who shall do field and office work under the direction of the regular Secretary. Success in this work will fit a candidate for an independent assignment in the national service, or in a State Department of Health. (See "Administrative Careers", p. 633.)

C. I. O.

Organized medicine in the main has long been favorably disposed towards the aims of organized labor. The majority of physicians have been sympathetic with the desire of those employed to improve their standard of living with an increase in wages and lessened hours

of labor where possible. The medical man himself is a day (and night) laborer. What he accomplishes he does largely with his own two hands directed by his brain. The majority of physicians are not employees of an individual or a corporation; but they are employees of a large number of employers, i. e., patients. Very few physicians owe their income to the labor and work of others except insofar as the efforts of necessary assistants and co-workers may be so considered. The twenty-seven million citizens of this country who are classed as those gainfully employed by others form a large bulk of the physicians' patients. The physician through training and experience is interested in human welfare. From an idealistic standpoint therefore he can be usually counted on to take the side of so-called human rights versus property rights. From a personal standpoint he also may be counted upon to be interested in the increased prosperity of a large number of his patients, who will be better able to pay for his services. Nevertheless, the rumor that the C. I. O. is attempting to organize non-professional hospital employees first and the nursing profession secondarily is viewed with alarm by the medical profession. The object of such unionization can, of course, only be to raise the pay of such employees and shorten their hours.

The vast majority of the hospitals in this country other than those owned and operated by government are so-called voluntary community hospitals. They are institutions organized on a charitable basis, and not run for profit. The vast majority of them go in the red every year; and such deficit in the past has been made up by private philanthropy. Due to the shrinkage of such philanthropy because of economic depression and increased taxation, many of these hospitals have trouble enough now to keep open. These institutions are not deliberately paying a small wage to their employees, nor keeping them on duty for long hours in order that they may make money out of the backaches of their employees. As physicans, we recognize that an eight-hour day is long enough for anyone to work. Some of us doubt that the world's work can be done in a thirty- or thirty-six-hour week, but certainly a fifty-six- or seventy-hour week is entirely too long, although we have never been able to reduce our hours to a fixed schedule.

If organized labor, under any leadership, wants to improve the condition of hospital employees and shorten the hours for the nursing profession, they can best do this through using their influence and their money to increase the income of hospitals. They may rest assured that, where institutions have the means, they are more than glad to pay their employees a living wage and to reduce their hours to a reasonable schedule. Organized labor can help to see that public funds are directed to the help of hospitals taking care of those unable to take care of their hospital bills. They can use their political influence to curtail, if necessary, the construction of new roads, the building of new public buildings or additions thereto, where not absolutely necessary. They can raise their voice to reduce unnecessary doles which oftentimes are political handouts. They can use their strength to reduce as rapidly as possible the amount of made work for which public money is going as fast as legitimate jobs are available. They can urge their members and their local unions to contribute towards the support of their local hospitals. Many local unions are in a position to endow a bed in a local hospital. They can interest themselves in having their members take out *voluntary* hospital insurance, and in many other ways take an active interest in supporting their community institutions.

If organized labor at this time seeks to lay an additional burden upon our charitable institutions, it will act as a boomerang. Many of their own members who have in the past received care for which they paid less than cost or nothing in time of emergency will not find such help available in the future if community hospitals are forced to curtail their service to the community through increased cost or lessened personnel. Organized medicine, which also has its share of influence, will not be able to stand supinely by and see the work of their hands undone. "Whom the gods destroy, they first make mad." Neither organized medicine nor organized labor can accomplish anything in this country without the force of public opinion on its side.

W. G. Herrman.

ORIGINAL ARTICLES

CANCER NIGHT OF THE BERGEN COUNTY MEDICAL SOCIETY

The regular monthly meeting of the *Bergen County Medical Society* was held in the Memorial Hospital, Eighth Avenue and 106th Street, New York City, on December 8, 1936, the members being transported in buses from Hackensack, N. J. The subject was "Cancer", and the program was provided by members of the Hospital Staff.

THE PRACTICAL ADVANTAGES OF SUBDIVISION OF TUMOR TYPES

By James Ewing, M.D.,
Director Memorial Hospital, New York City

Introductory remarks at the "Cancer Night" of the Bergen County Medical Society, December 8, 1936.

The classification of tumors according to grades of malignancy, variations in clinical course, and tendency to metastasize, forms an important department of present day laboratory diagnosis. Yet some pathologists depreciate the importance of grades of malignancy, and suggest that there is no general relation between malignancy and the course and outcome of the disease. This conclusion is apt to be reached when a comparatively small amount of material is encountered, because the great majority of cases of any one type of carcinoma fall into intermediate grades of malignancy, and run the average course, depending mainly on the extent of the disease when first treated. Only about 20 per cent of cases fall into the extreme grades, high or low; and when the material is small, these extreme cases are not impressive and appear merely as exceptions to the rule. Yet experience shows that there is much practical value in attempting to distinguish as far as possible, between grades of malignancy and peculiar clinical types of disease, because such refinements of diagnosis and classification greatly aid the surgeon in directing treatment and in forestalling complications.

In no department is this rule more evident than in the group of *epidermoid carcinomas.* This group was formerly considered as rather simple, and adequately subdivided into *squamous* and *basal cell carcinomas.* Modern study, however, reveals that epidermoid carcinomas show many varieties which differ greatly in structure, grades of malignancy, radiosensitivity, tendency to metastasize, and general prognosis, all of which features must be considered if the case is to be competently handled. These types may be classified as follows:—

1—*Squamous carcinoma,* with keratin formation, pearl formation, early invasive tendencies, often early metastases, and varying grades of histological or potential malignancy.

2—*Basal cell carcinoma,* Rodent ulcer. Hair matrix carcinoma, slowly growing, uniform moderate malignancy, late or no metastases, tendency to local recurrence.

3—*Adenoid cystic basal cell carcinoma,* arising usually from cutaneous glands, resembling in structure ordinary basal cell carcinoma, but producing more active growth with many or few mucous cysts, producing widespread metastases.

4—*Transitional cell carcinoma,* arising on mucous membranes lined by transitional stratified epithelium, without keratin or pearl formation, actively growing, tending to produce early metastases, and rather radiosensitive.

5—*Lymphoepithelioma,* arising from mucous membranes which are lined by delicate stratified epithelium often infiltrated with lymphocytes, and appearing in pharyngeal wall, tonsil, base of tongue, and thymus, giving small slowly-growing primary tumors often overlooked, but producing early local and late distant metastases and always highly radiosensitive.

6—*Spindle cell epidermoid carcinoma,* a peculiar form in which the epithelial cells appear in spindle form, resembling sarcoma, generally appearing as a secondary structure in original squamous carcinoma, malignant, metastasizing and radioresistant.

7—*Pigmented epidermoid carcinomas,* resembling melanoma, but producing pigment as the result of hemorrhage or chonic irritation, or accumulation or foreign material. The exact relations of some of these pigmented epidermoid carcinomas are not always clear, but they do not run the course of true melanoma.

Unless the surgeon is familiar with these subdivisions of epidermoid carcinomas, he will be frequently disturbed by unexplained eccentricities, peculiarities, recurrences, unexpected metastases, and strange complications in the course of treatment. Similar situations exist with many other major forms of cancer.

PRIMARY CARCINOMA OF THE LUNG

By Lloyd F. Craver, M.D.,
Attending Physician, Memorial Hospital, New York City
Read before the Bergen County Medical Society at the "Cancer Night" on December 8, 1936

The treatment of primary carcinoma of the lung up to the present has been far from satisfactory. The remarkable technical advances in thoracic surgery in recent years are unfortunately of limited avail in this field. Relatively few cases of carcinoma of the lung are actually suitable for attempts at surgical removal by the time a diagnosis is made under present conditions. No doubt greater alertness for making the diagnosis, and increased practice of bronchoscopic examination will discover a somewhat greater proportion of cases in time to make lobectomy or total unilateral pneumonectomy feasible. However, a true perspective of the disease in all its variations indicates that even under the best available modern conditions there will remain a large proportion totally unsuitable for surgery.

X-RAY TREATMENT

Must these inoperable cases be abandoned to passive observation and medicinal palliatives? It now appears that by irradiation a good number of them can receive distinctly worth-while relief from symptoms, and at least temporary growth restraint. Since application of the protracted divided dose method of irradiation by high voltage x-rays to this field, we have found marked early palliation in 43 per cent, as contrasted with only nine per cent of marked early palliation that resulted from the older method of giving a few single large doses of x-rays. We still cannot point to proven cures of long standing, but on the basis of established palliative results, we may reasonably hope that further improvements in technique of irradiation may make it possible to obtain longer growth restraint and possibly definitive cure in some cases.

The following report is presented as an example of what may be done for some cases by irradiation.

Case 2—H. M., a married woman of 56, was admitted to the Memorial Hospital November 30, 1934. On April 1, 1934, she had developed pneumonia, supposedly at both bases, but more marked on the left side. She was somewhat delirous for three weeks, but then improved. However, she had a persistent fever, and examination indicated a left pleural effusion. Thoracentesis yielded a small amount of fluid, in which influenza bacilli were found. She lost 27 pounds, continued to have fever and a persistent cough, with slight expectoration and no hemoptysis.

Early in November lipiodol films suggested a mass in the left lower branchus. November 20, bronchoscopy at another hospital disclosed a growth in the left lower bronchus. Biopsied tissue, reviewed at Memorial Hospital, showed grade three carcinoma, radiosensitive. On admission she was dyspneic, had a persistent irregular fever and frequent cough. Examination of the chest showed slight dulness, but markedly diminished breath sounds over a wide area at the left base posteriorly. No other evidence of the disease was found on physical examination.

Study of the lipiodol films made elsewhere strongly suggested a limited mass in the left lower bronchus, about four centimeters in diameter.

In planning treatment it was decided to assume that this mass represented the extent of the tumor, and to ignore the peripheral clouding, assuming that the latter represented atelectatic and inflammatory changes.

Through a square port 9 x 9 centimeters anteriorly, and a similar one posteriorly over the tumor, high voltage x-rays at a target-skin distance of 70 centimeters were given to a dosage of 12 x 300 r units to each port within one month. Moderate radiation sickness resulted, but on the whole the treatments were well tolerated. The skin showed a sharp erythema, without vesication, and eventually healed, with a scarcely noticeable atrophy.

Towards the end of the series of treatments physical examination indicated increased aeration of the lower lobe. During the second month following the irradiation the patient was ill at home with a fever of 101.5 to 102°. Various consultants examined her, and a suggestion was made that endobronchial cauterization be done to improve drainage. However, this was not done, and two months following treatment she returned, having improved so much that she felt better than at any time since her illness began. She had gained five pounds in weight.

At that time the first clear indication of regression could be found in her chest film. This regression slowly continued so that by October 1935, nine months following treatment, the chest film showed practically complete clearing of the opacity in the left lower lobe. However, in June 1935, she had moderate repeated hemoptysis for one day. This did not recur. Physical signs of non-aeration of the left base gradually diminished. From the late summer of 1935 to the present time, December 1936, the patient has carried on a fairly normal life, occasionally playing tennis or golf, and working steadily as an interior decorator. Examination of the chest in November 1936, indicates practically normal aeration of the left lower lobe. The last chest film, November 1936, shows a completely clear left base, and no distinct evidence of disease.

Her case, therefore, represents a two-year control, by means of irradiation, of carcinoma of the bronchus of a high grade of malignancy.

OSTEOGENIC SARCOMA OF HUMERUS

A CASE PRESENTATION

By Norman L. Higinbotham, M.D.,

Assistant Surgeon, Memorial Hospital, New York City

Read before the Bergen County Medical Society meeting at Memorial Hospital, December 8, 1936, at its "Cancer Night"

OSTEOGENIC SARCOMA OF HUMERUS

K. H., female, aged 12, was admitted to the Memorial Hospital on November 15, 1935. She gave the usual history of insidious onset of pain in the right shoulder two years previously. Swelling of the shoulder soon followed, and she was taken to a mid-wife who tried massage for one month without affecting any improvement. She then went to a physician who took an x-ray of the affected region and made a diagnosis of tumor. He prescribed x-ray therapy. This was given in March 1934, to the point of good skin reaction (details of dose and technic not available). Subsequently she went to another Tumor clinic in the city where in October 1934, a radium pack was applied giving 15,000 milligram hours at six cm. distance through two ports. Later the patient was referred here for an opinion and further treatment.

On admission she presented an oedematous right upper arm with marked radiation changes of the skin below the shoulder. The skin was healed and there was no ulceration, but there was no motion at the shoulder and very little function of the elbow and hand.

X-ray film showed extensive destruction of the upper end of the humerus typical of osteogenic sarcoma. Comparison of this film with others previously taken, disclosed the process to be slowly and steadily advancing despite the irradiation program.

The chest films were negative for metastasis, and as no further irradiation could be given, an amputation was decided upon. Accordingly, an interscapulothoracic amputation was performed on November 11, 1935, by Dr. Bradley L. Coley, and was followed immediately by a transfusion of 500 c.c. whole blood. Due to the irradiation changes in the skin, it was impossible to approximate the wound margins at the time of the amputation, but four weeks later, pinch grafts were applied to the clean granulating area of the stump, and these took well. During convalescence the patient was given 15 injections of Coley's toxins, with good reactions from each, and she was discharged from the hospital, five weeks after the operation, in good condition.



Osteogenic sarcoma of the upper end of the humerus in a twelve-year-old girl. After heavy irradiation and subsequent amputation, patient was well three years from onset and one year after interscapulothoracic amputation.

The stump has remained well healed without evidence of extension or recurrence of the tumor, and x-ray film of the chest taken two weeks ago (November 22, 1936) is negative for pulmonary metastasis.

This illustrates a case of osteogenic sarcoma of the upper end of the humerus in a twelve-lear-old child, well three years after onset, and one year after amputation, following extensive irradiation therapy.

WILMS TUMORS OF THE KIDNEY

By ARCHIE L. DEAN, M.D.,
Associate Urologist, Memorial Hospital, New York City
Read before the Bergen County Medical Society at its "Cancer Night", December 8, 1936

Wilms tumors are congenital embryonal neoplasms of the kidney. They usually occur in infancy. In most cases serious illness is unsuspected until the mother or a nurse discovers a mass in one side of the child's abdomen. Occasionally the early symptoms are a gradual and progressive abdominal distension, or increasing malaise and constipation.

If the earliest symptoms are neglected, there may be a sudden augmentation of symptoms such as vomiting, loss of weight, asthenia, anorexia, increased rate of tumor growth, and the appearance of tortuous, dilated, superficial veins. Urinary signs are usually insignificant and unimportant. Probably this is because the tumor is separated by its capsule from the kidney parenchyma.

Hematuria is usually due to hemorrhage from the congested parenchyma of the kidney rather than from the tumor proper. It may occur in the early stages of tumor growth before the calyces are completely compressed. The blood usually appears diffuse throughout the urine. Occasionally blood casts of the ureter have been voided.

Pain is not an important feature. It may be colicky as the result of constipation, or it may occur when the tumor grows rapidly and exerts tension on the renal capsule and possibly traction on adjacent organs. The growth is not tender to palpation. Indeed, the "silent" nature of this noeplasm is remarkable. Because of its enormous size in some cases, the child may be able to walk only with great difficulty.

EARLY DIAGNOSIS

Wilms tumors characteristically spread aggressively by continuity. Also extensive growth frequently takes place within veins, and as a result metastases to the lungs are among the first demonstrable. In the attempt to control a tumor which grows with such extraordinary rapidity, and mestastasizes so early, it is essential that no time be lost before the diagnosis is established. This should not be difficult because a competent urologist with modern equipment can make a complete examination of the youngest child of either sex. Fortunately, however, in most cases a diagnosis can be made on the basis of excretory pyelograms alone. One should never incise a Wilms tumor to obtain material for histological study because, as soon as the capsule has been broken, exceedingly rapid growth takes place in all directions.

X-RAY, PLUS SURGERY

Obviously the management of this disease is difficult, for by the time the condition has been recognized it is usually far advanced. However, because the tumors are composed of radio-sensitive embryonal tissues, roentgen therapy has proven valuable. We treat patients by either one of two methods, each of which depends largely or entirely upon external irradiation. As yet we are undecided as to which method offers the greater hope.

If a careful examination shows no metastases, three portals are marked on the patient, anterior, lateral, and posterior, each portal centered at the mid-point of the tumor, and each large enough to cover the tumor. Rarely, if the tumor is especially large, additional portals may be needed. A target skin distance of fifty centimeters is used with one-half millimeter of copper filtration. 150 r units are given a single portal daily, and the portals are treated in rotation.

In a short time, usually about three weeks, palpation, measurements, and excretory pyelograms will show that the kidney with the tumor is little, if any larger, than the normal, opposite kidney. At this time nephrectomy is performed. Although the greatest care is exerted to avoid trauma, which might disseminate tumor cells, the operation is not especially difficult. We give postoperative irradiation.

RADIATION ALONE

The second method of treating Wilms tumors is by irradiation alone. The same treatment is given as in the cases operated upon. However, when the tumors have nearly, if not quite disappeared, the daily exposures are reduced from 150 r to 75 r. If no tumor is demonstrable when 2000 r have been given each portal, a rest period of about two months is given. Since the minimal dose of radiation required to cure a Wilms tumor is unknown, and because tumors differ in radio-sensitivity, each case should be treated individually on the basis of careful daily examinations.

Infants, as a rule, are relatively intolerant to intensive irradiation. A diminution of the white blood cells is one of the earliest signs that the limit of treatment may soon be

reached. For this reason, a complete blood count is made every two to three days, and transfusions of whole blood are given whenever indicated, the amount depending on the size of the child. In addition, we take roentgenograms of the chest every two to three weeks to detect lung metastases as early as possible.

If metastases are present at the time the patient is first seen, irradiation alone is used. This gives palliation to a considerable degree, and in some cases has caused complete disappearance of lung metastases. Unfortunately in our cases metastases sprang up elsewhere and eventually caused death.

CASE REPORT

The small patient I will show you this evening is being treated exclusively with radiation. This infant, H. S. (M. H.), appeared quite normal at birth. In March, 1936, when seven months old, she had abdominal colic accompanied with diarrhoea and vomiting. Under symptomatic treatment she recovered and seemed well for six weeks. Then the same symptoms returned and in addition blood and pus were found in the urine. The diagnosis of pyelitis was made and medical treatment for this condition was given for several weeks with little improvement. In May, 1936, a mass was found in the left side of the abdomen but nothing was done for five more months while the question was being debated as to whether the mass was kidney or spleen. Finally in October, 1936, excretory pyelograms were made which clearly demonstrated a tumor of the left kidney which filled the left abdomen and extended into the bony pelvis and across the mid-line. (Roentgenograms shown.)

When referred to us, the general condition of the infant was bad, but no metastases could be found. It was decided to use irradiation alone largely because the disease appeared so far advanced, and after a transfusion of 200 cubic centimeters of whole blood, treatment was started. Improvement was rapid and has steadily continued. At present there is no palpable evidence of tumor and the excretory pyelogram shows the left kidney to be within normal limits. (Pyelograms shown.) To date, 1800 r have been delivered to each of three renal portals, and there is only the slightest tanning of the skin in the regions treated. The blood counts have shown moderate variation, especially in the numbers of the white blood cells; but now, after a second transfusion the count is normal. For the past two months the general development of the child has been normal.

ADENOCARCINOMA OF THE HARD AND SOFT PALATE

By William L. Watson, M.D.,
Associate Surgeon, Memorial Hospital, New York City

Read before the Bergen County Medical Society at its "Cancer Night" on December 8, 1936

The following report is of some importance and interest not because the patient has been well and free of disease for any great length of time, but rather because the case has been so typical as to its history, previous treatment, treatment while at Memorial Hospital, and post-operative course.

Intraoral adenocarcinomas are derived either from minor salivary glands of the oral cavity, aberrant thyroid tissue, or from mucous glands. Their micropathology is fairly constant, but the gross appearance is diagnostic. These growths have a marked tendency to local recurrence, bone invasion, and widespread metastasis by way of the blood or lymph stream. They are not as a group radiosensitive. Our present treatment has been for the most part by a combination of heavy external and interstitial irradiation, followed by cautery excision.

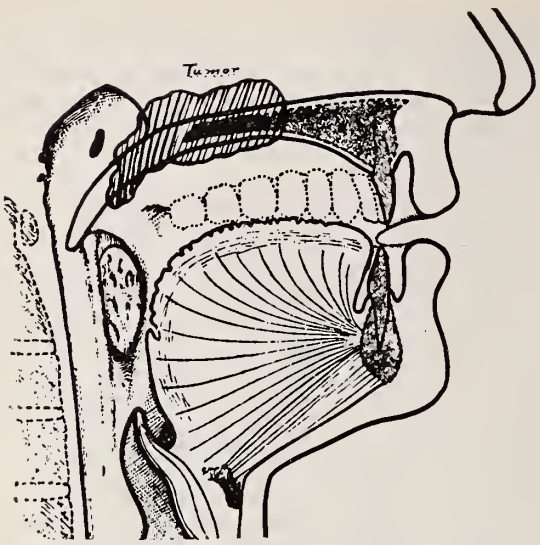
CASE REPORT

Mrs. P. S., a Scottish housewife forty-eight years of age, complained of frontal and orbital headaches of many years' duration, and gave a long-standing history of unrelieved maxillary sinusitis and nasal polypae. Mastoiditis had developed in December, 1921, and necessitated a left mastoidectomy.

The patient herself noted a bulging of the soft palate in February, 1927, and during the ensuing year received radium treatments on five different occasions. The tumor apparently regressed for a period, and then returned; and in June, 1930, a recurrent mass of tumor tissue in the soft and hard palate was removed by an intraoral surgeon. A second recurrence was noted in February, 1934, and patient applied to Memorial Hospital for treatment June 20, 1934.

Tumor.—On examination the tumor was found to involve the major portion of the hard and soft palate, and extended into the floor of the nasal passages and adjacent nasopharynx. As nearly as one could judge, its size was 3 x 2 x 2 centimeters. It was nonulcerated, and showed the scars of previous operative procedures. In consistency it reminded one of hard rubber. On histological examination of a surgical section, Dr. F. W. Stewart reported "Mucous gland (salivary) adenocarcinoma; local recurrence probable; dissemination unlikely". Suitable roentgenographs revealed invasion of the hard palate and left maxillary sinus.

Treatment.—The following data give the essen-



Sagittal section through the tumor showing its involvement of the nasopharynx, nasal passages, hard and soft palate.

tial factors in this patient's treatment both before and after her admission to Memorial Hospital:

1. Radium treatment before admission to Memorial Hospital:
   a. 3-19-27—4 x 5 mg. pl. needles 3 hrs. 60 mghr.
   b. 3-30-27—6 x 5 mg. pl. needles 2½ hrs. 70 mghr.
   c. 4-19-27—80 mg. brass capsules 1½ hrs. 120 mghr.
   d. 5-9-27—120 mg. brass capsules 1½ hrs. 180 mghr.
   e. 8-9-27—4 x 5 mg. pl. needles 1½ hrs. 30 mghr.
2. Excision by endotherm cautery, June, 1930.
3. Gold filtered radon seeds:
   a. 17.4 mc.—7-27-34.
   b. 10.7 mc.—8-30-35.
   c. 11.0 mc.—9-29-35.
4. X-ray therapy: 7-30-34 to 8-25-34. Total 2400 r x 3:
   a. Left malar portal 7 cm. 300 r q. 3 d.
   b. Right malar portal 7 cm. 300 r q. 3 d.
   c. Intraoral Cylinder 3 cm. 300 r q. 3 d.
5. Operations:
   a. Cautery excision 9-25-35.
   b. Removal of polyps 10-9-35.
   c. Incision and drainage of left mastoid abscess 11-8-35.
6. Upper denture and prosthetic appliance by Dr. Andrew Ackerman.

Complications.—After removal of the soft palate, uvula, and practically all of the hard palate, one would expect some very trying postoperative complications, and such was the sequence of events in this case. First a bilateral purulent otitis media developed, followed by a left mastoiditis and abscess which required drainage. Severe facial erysipelas developed, and was followed by a right mastoiditis. Nearly a year later empyema of the sphenoid sinus occurred and the floor of this sinus was removed for drainage purposes.

Course.—All during this patient's convalescence and up to the time she was fitted with an upper denture and prosthetic appliance, the taking of food was a major problem, and for some little while this had to be carried out by means of nasal feedings. At the present time she is without evidence of disease. She has put on over twenty pounds in weight, and has no difficulty in eating a normal diet. Her voice is practically normal.

1088 Park Avenue
New York, N. Y.

INFILTRATING ADENOCARCINOMA OF THE PROSTATE, GRADE III

Controlled From September 11, 1928, to Date

By Benjamin S. Barringer, M.D.,
Urologist Memorial Hospital, New York City

Read before the Bergen County Medical Society on its "Cancer Night", December 8, 1936, in the Memorial Hospital, New York City

Patient first came to Memorial Hospital September 11, 1928, at the age of 70 years, with a history of ten years of urinary frequency. Three years before he was seen, frequency increased in severity and was accompanied by great urgency, nocturia, and occasional difficulty in starting the flow of urine.

Rectal examination showed the prostate about twice normal size. The right side was enlarged, stony-hard, and was close beneath the rectal mucosa. The right seminal vesicle was involved with the growth; left seminal vesicle was not involved. The urine was clear. No residual urine. The diagnosis was made of *carcinoma of the prostate,* which had grown beyond the prostate capsule and involved the posterior lobe. Cystoscopic examination at that time was not done.

His prostate was treated with unscreened radium contained in the end of long needles. These needles were introduced through the perineum into the right and left lobes of the prostate, and into the right seminal vesicle. 450 mc. hrs. of unfiltered radium was the initial dose.

He also had deep x-ray therapy from five

portals of entry,—right and left pelvis anteriorly, and right and left pelvis posteriorly, and the perineum. The portals were 10 x 12 cm., with the perineal portal 6 x 6 cm. Each dose was approximately 750 r units, with the perineal dose 500 r's.

He continued to empty his bladded completely. His prostate felt two months after the radiation absolutely normal. Later he was operated for gallstone disease. He began to have difficulty in emptying his bladder, August 6th, 1935. His prostate felt normal, but he had two ozs. residual urine. Because of this, and because of the increased frequency of urination, a trans-urethral prostatectomy was done. We believed at that time that the condition was fibrosis of his bladder neck. The specimen removed trans-urethrally showed: "Infiltrating Adenocarcinoma of the Prostate, Gr. III". He progressed favorably, soon getting back to a full day's work.

His prostate was again treated through the perineum by prostatic needles containing radon, screened by gold, with a total dosage of 1500 mc. hrs.

The prostate at the present time feels somewhat sclerosed, with no suspicious nodules in it. He empties his bladder, and at the age of 78 is doing a full day's work.

It is dufficult to tell whether or not there is any more carcinoma left in the prostate. He is being watched carefully.

IDIOPATHIC MULTIPLE HEMORRHAGIC SARCOMA OF KAPOSI

By George T. Pack, M.D.,
Attending Surgeon, Memorial Hospital, New York City

From the Mixed Tumor Service of the Memorial Hospital for Cancer and Allied Diseases, New York, N. Y.
Read before the Bergen County Medical Society at its "Cancer Night" on December 8, 1936

Kaposi in 1872 attempted a classification of the various sarcoid tumors of the skin. Among the sarcoids were certain tumors now recognized as lymphoblastomas, and tuberculous granulomas of the skin. One group of idiopathic hemorrhagic skin lesions was considered a clinico-pathologic entity, and has since come to bear the eponym of Kaposi's disease. The rarity of this condition may be appreciated by the fact that only 400 cases have been recorded in medical literature. It seems to occur predominantly in Jews, Italians, and Slavs, but isolated cases have been reported from all parts of the world and in all races. Our experience with this tumor includes twenty-four cases from the Mixed Service of the Memorial Hospital and from several tumor clinics in general hospitals.

The patient whom you are inspecting presents many features of this remarkable disease. He is a seventy-two-year-old Russian Jew, who has had multiple tumors involving both lower extremities for the past three years. The incidence is highest in the sixth and seventh decade, although we have one patient twenty-five years of age who is living and well four years after the institution of treatment. The location on the lower extremities is characteristic and is the primary site in the majority of patients. The edema of this patient's feet and ankles preceded the appearance of the tumors and may have an etiological bearing, as will be pointed out later. You will observe the bilateral distribution of the skin lesions, which points to a common underlying cause of these tumors. Although a single tumor may appear, the rule is for them to be multicentric in origin, in which case the later appearing tumors or those on the opposite extremity are not necessarily metastatic in character.

STAGES

On close inspection, the three variants representing stages in evolution of the disease may be seen in this one patient. The small, flat, brown or blue *macule* is the earliest manifestation; it is not nodular as yet, and shows only inflammatory changes on microscopical study. The blood and lymph vessels are dilated; there is perivascular round cell infiltration, and also hemorrhage.

The later and larger nodular lesions is essentially granulomatous rather than neoplastic; the bulk of the nodule is composed of proliferating connective tissue and proliferating small blood vessels and lymph vessels. In color, these nodules vary from reddish brown to blue. They are occasionally tender.

The final or neoplastic phase of the lesion is seen in the larger nodules, and particularly in the confluent, serpiginous tumors seen here on the dorsum of each foot and over the tibias. These efforescent tumors sometimes become ulcerated and bleed, but more often they remain flat, discoid and covered with brown scaly epidermic plaques. The neoplastic lesions vary

in their microscopical picture with the tissue elements involved, e. g., when the changes are principally vascular, the tumors may resemble angiomas, lymphangiomas, angiosarcomas, and endotheliomas. When the connective tissue elements predominate, the tumors are either fibromas, angiofibromas, or spindle cell sarcomas.



Fig. 1.—Photograph showing the distribution of the lesions



Fig. 2.—Enlarged section of the ankle region of Fig. 1, showing the appearance of the lesions

Idiopathic Multiple Hemorrhagic Sarcoma of Kaposi

The color, shape, confluence, multiplicity, consistency, tenderness, and vascularity of these tumors offer a sufficient explanation for the original opinion that they were infectious. Indeed they are not unlike certain tuberculous sarcoids, tertiary syphilides, yaws, leprosy, mycosis, and even lichen planus. We excised two of these tumors, and with the patient's consent reinoculated his uninvolved skin with finely morcellated tumor and with a Berkfeld filtrate of the tumor suspension; but as you see, there have been no new lesions at the sites of these inoculations. Similar experiments have been unsuccessful, with one questionable exception, especially when an attempt has been made to transfer the disease to lower animals.

ORIGIN

The varicosities in this patient's legs and the nodular beading of his peripheral vessels may be coincidental and unrelated, but their coexistence is common; it is another indication of the vascular origin of this tumor. Microscopical sectioning of the thickened walls of some of the larger blood vessels have shown the identical structure of these hemorrhagic sarcomas. It is now believed that the tumor originates from the rather complex vascular neuromuscular annexes and Schwannian elements; in this sense it is the malignant counterpart of the benign tumor of the glomus.

TREATMENT

How shall we treat this patient? First we must realize that he has a systemic disease, and that we shall treat only the external evidence. If he had been available for treatment shortly after the appearance of the first tumors, we would have been justified in giving more vigorous radiation therapy in the hope of permanent control.

A second point to be remembered is that the course of Kaposi's sarcoma is slow, with an average duration of five to ten years before the patient dies of intercurrent disease, infection, hemorrhage, cachexia, or extensive visceral involvement, particularly of the gastrointestinal tract. I have seen patients treated by intensive low voltage x-ray therapy in large doses in whom excellent primary results have occurred, only to have the patients live sufficient years afterward to suffer painful radionecrotic lesions, and in addition new tumor nodules in skin too badly damaged to tolerate further radiation therapy. We shall therefore treat this patient by the application of small radium plaques for the discrete tumors, and unfiltered low-voltage x-ray therapy for the larger tumors, giving fractionated treatments of sub-erythema doses. Surgical excision is of little value except for the single tumor. Radiation therapy should be employed; and when it is properly administered, is gratifyingly successful.

A NASOPHARYNGEAL TUMOR

By James J. Duffy, M.D.

Associate Attending Surgeon, Assistant Radiotherapist, Memorial Hospital, New York City

Read before the Bergen County Medical Society on its "Cancer Night", December 8, 1936, in the Memorial Hospital, New York City

This patient will serve to illustrate a case of nasopharyngeal carcinoma, with cervical metastases, in a very young subject; and the apparent cure of the disease. This disease is difficult to control and is especially malignant in children. The patient had a series of complications, which were, for the most part, consequent upon the treatment.

A. L., now aged nineteen, came to the hospital July, 1930, at the age of thirteen, complaining of lump in the upper right neck, which he first noticed six months before. At that same time he began to have headaches. The lump gradually increased in size, and in May, 1930, a biopsy was done elsewhere and a diagnosis of squamous cancer was made. He had lost fifteen pounds in weight, and his appetite had been very poor.

On examination there was a papillary, sessile mass, one-half cm. in diameter, and elevated two mm., situated in right nasopharynx. There was one hard, fixed, node under right upper end of sternomastoid two cm. in diameter, evidently infiltrating muscle. There was one very soft node one cm. in diameter over left carotid bulb, clinically inflammatory. Biopsy report: Lymphoepithelioma, radiosensitive.

He was given external radiation with the Radium Element Pack, 16,000 mgm. hrs. at six cm. distance to each side of the neck from July 13 to 17, 1930. The node in the left neck did not completely disappear. He was then given external radiation with the Radium Element Pack 16,000 mgm. hrs. at six cm. distance over each antrum over a period of four days, July 23 to 26, inclusive.

On July 28, under general anaesthesia, tubes of radon, amounting to 8.6 mcs., were implanted into the lesion of the nasopharynx, and 19.41 mcs. of radon in gold tubes were implanted into the node of right neck.

About two weeks later a peroneal palsy developed on the left side. There were no symptoms of poliomyelitis. It was undoubtedly the result of toxic absorption, due to breakdown of the nasopharyngeal tumor, and the severe reaction over neck from external irradiation and buried emanation.

In October, 1931, there was no evidence of disease in the nasopharynx, although the one soft node over left carotid bulb persisted.

In January, 1931, patient had a severe herpes zoster of right supraorbital nerve, with severe pain and large vesicles, which later ulcerated, causing scars which still persist. At this time the persistent roughening of nasopharynx appeared suspicious of recurrence, but biopsy showed only granulation tissue.

In August, 1932, a questionable node appeared in the right posterior submaxillary region, one and a half cm. in diameter. This was aspirated, but no neoplastic cells were found.

Three years after treatment, he complained of blurred vision, which he stated he had had for about a year. Examination showed a posterior cortical cataract of each eye, the greater opacity on right. Vision of right 20/50ths, left 20/40ths. The cataract of the right eye, and later the lesion of left eye were removed.

At this date, December 18, 1936, there is no evidence of disease in nasopharynx or neck.

HYPOGLYCEMIC SHOCK THERAPY IN SCHIZOPHRENIA

A PRELIMINARY REPORT

By Theodore R. Robie, M.D.; Warren I. Reinhardt, M.D., and Arthur R. Abel, M.D., East Orange, N. J.

Presented at the Northern New Jersey Neuropsychiatric Association, Newark, N. J., on February 17, 1937.

In August, 1936, it was the good fortune of one of the co-authors to encounter socially a psychiatrist who had just returned from a tour of Europe, much enthused over the new insulin treatment for dementia praecox which had originated in Vienna. He had visited Sakel's clinic, and had seen the patients under treatment and studied the records, and was so convinced of its value that it was his intention to begin treating cases at his hospital immediately. His enthusiasm was contagious, for immediately one of the co-authors exerted every effort to secure the original article by Sakel, which was translated through the aid of a student of scientific German. Then, with the collaboration of psychiatrist, pathologist, and physician, this new radical medical procedure was instituted. A catatonic schizophrenic patient at Mountainview Rest Sanitorium was considered a suitable case for treatment, which was started in late October, 1936. The improvement under hypoglycemic shock therapy was so apparent and marked that about two weeks later we were emboldened to institute this treatment on a second case—a hebephrenic schizophrenic.

Dr. Bernard Glueck's article in the September 26, 1936, Journal of the American Medical Association, the first to appear in English on the subject, encouraged us in this decision, for in this article Dr. Glueck stated:

> "Should the results reflected in these statistics (from Sakel's one hundred and four treated cases) prove to be entirely permanent, or even considerably so, the discovery of this method of therapy for the psychoses will constitute, because of its far-reaching biologic, medical and social implications, one of the greatest achievements of medicine."

Since the publication of this preliminary paper, later published reports from Sakel's and other clinics have justified the continued enthusiasm for this new startling but dangerous therapy for the most malignant and widespread mental disorder of modern civilization.

In a paper which appeared in the October, 1936, New York State Medical Journal, Dr. Glueck again wrote:

> When, as it appears from these statistics, as many as over three-fourths of the (schizophrenic) patients who had been ill less than a year, make complete recoveries, and over 68 per cent of those who have been ill less than one and a half years are similarly benefited, *it would appear reasonable to subject every new case of schizophrenia to this form of therapy.*

The statistics come from Sakel's work in Potzl's Vienna clinic (104 cases), and Switzerland (118 cases from ten different hospitals). As yet no statistics have been published on any sizeable group of cases treated in this country, although the treatment has been instituted in various hospitals recently.

In a short editorial in the November 21st Journal of the American Medical Association, it was pointed out that present opinion indicates that the treatment should be employed primarily in early cases. It was admitted, however, that even in cases of long duration satisfactory results sometimes occur, and the statistics bear this out as follows: Of the fifty-eight recent cases, 88 per cent showed good recoveries; i. e., went back to their former occupations in the community; and 71 per cent of the total showed complete recoveries. Of the forty-six older cases (duration more than one and a half years), a good social recovery occurred in 48 per cent, whereas a complete remission occurred in 20 per cent of the cases.

On January 12, 1937, a symposium on this new treatment was held at the New York Academy of Medicine. A packed auditorium heard Dr. Sakel himself describe his startling new treatment; and there followed a report by Dr. Glueck on seven cases treated in his sanitarium, and another report on thirteen cases treated by Dr. Joseph Wortis in Bellevue Hospital. In Wortis' series of cases, although four were unchanged, nine had been definitely bene-

fited by the treatment, and of ten recent cases, three already show full remission. Dr. Glueck pointed out how impressive it was to watch the decrease in need for sedative medication, and the way in which seclusive patients begin to enter into social activities relatively soon after therapy was begun. He commented:

> No one accustomed to psychotherapy will accept the view that a purely physical approach is all that is necessary in these cases—the psychological approach is all the more necessary and the treatment gives one a peculiarly better opportunity for rapport. (Anyone instituting this treatment on inaccessible schizophrenics will quickly appreciate its value in this respect.)

Of the seven cases treated by Dr. Glueck, two have been discharged, two others were ready to be (January 12th), and in three other cases no comment could be made as treatment had not been carried out for a sufficient period. Many outstanding neuropsychiatrists, even from distant parts of the country, were present and entered enthusiastically into the discussion, commenting on the remarkable results reported. Adolph Meyer said, "This is something that has not happened very often in psychiatry"; and he urged that further studies be carried on under carefully controlled conditions in the hands of well-trained and experienced psychiatrists.

THE METHOD

In this paper the method will be described only in outline, since the detailed description of Sakel's procedure is now available in the articles already referred to. Briefly, the patient is administered gradually increasing doses of insulin intramuscularly, on an empty stomach. When the dose has reached a level that will precipitate the patient into profound insulin shock, the temporary shock dosage has been found. This shock level is only an approximation, for it will be found that the individual's dose varies from day to day. The desirable reaction is such profound insulin shock (hypoglycemia) that the patient remains in deep coma for as long as desired, necessitating the administration of dextrose intravenously for its interruption. Occasionally, satisfactory shock levels may be reached at that point where the patient, through vigorous stimulation, may still be able to swallow carbohydrate by mouth. Adrenalin may be necessary under these circumstances.

The difficulty with this mode of coma interruption is two-fold: (1) The patient may not be able to swallow and aspiration of food may take place; (2) interruption in this manner extends over a considerably longer time than does interruption by the intravenous route, and in our experience the oral method has proven disadvantageous from a psychiatric standpoint because of the psychic trauma. The same objections hold for the use of the nasal tube as a general rule; but in an emergency when a vein cannot be found, the nasal tube may prove necessary.

The patient is allowed to remain in coma until such time as the clinician feels that further coma would be injurious. The fine point at which interruption of coma is necessary is determinable only through repeated observations. It must be remembered that once coma has been reached, it is not a static thing but grows progressively deeper, sometimes reaching a stage very suddenly when the patient appears in extremis.

The melodramatic part of the treatment comes at this stage, for the intravenous injection of an adequate amount of 50 per cent dextrose will bring a patient out of profound coma in less than a minute. Once out of coma the patient feels excellent as a rule, except for the discomfort of the profuse generalized diaphoresis, and at once carries on conversation with those around him. There are immediate demands for food, particularly carbohydrates. It is at this stage and in the following hour or two that the best opportunity is afforded for psychotherapeutic endeavors which play no small part in helping to eliminate the false ideas harbored by the patient. One must, of course, keep in mind that the patient may sink into a second coma at any time during the day—in spite of having ingested seemingly adequate amounts of carbohydrates.

Before describing our treated cases, it should be pointed out that the procedure is *complicated and dangerous,* and new decisions regarding each step must be made from day to day, and even from hour to hour. Principles of dos-

age have not yet been established, and often one is feeling in the dark when deciding upon this, but must be guided by the current reactions of the patient. Seemingly adequate dosage at one time may suddenly appear to be entirely too large, or the opposite—utterly insufficient. The reasons for the patient's altered reactions are as yet a mystery. Even the duration of each day's treatment must be determined at the time and decisions in this regard can be made only through constant bedside observation. The course of treatment is not smooth in any case—it is, on the contrary, very rocky and wholly unpredictable.

CASE I.

A robust white female of twenty-two years; onset of psychosis in July, 1936, immediately following an appendectomy. She had been somewhat nervous for a short time before the operation. The early picture was one of acute excitement with marked over-activity, elation and overtalkativeness, constantly expressing all sort of grandiose delusions. She believed that she had been picked to cure the world of all its evils, that she was to deliver many political speeches all over the country to purify politics everywhere; and that she had been given a special gift to deliver these speeches without any worry over their preparation. In the first few weeks under custodial sanitarium care she continued extremely excited and overactive, shouting and yelling almost constantly during the daytime, in spite of hydrotherapy alternating with wet packs as the occasion required. She was frequently destructive and assaultive during the brief intermissions between packs or hydrotherapy. She refused food regularly, and it was only through patient effort that the nurses were able to get her to take nourishment enough for sustenance, but she steadily lost weight.

After about four weeks of this type of psychotic reaction, the picture gradually changed so that her utterances became a steady stream of unintelligible jargon. Incontinence, which had occurred rarely before, became much more frequent. There was extreme regression in the element of bodily cleanliness—to the point of utter indifference to personal neatness, with infantile exhibitionism occurring spontaneously, accompanied by loud singing and childish laughter. For some weeks before the hypoglycemic shock treatment was instituted, the jargon of noises she had been making had been replaced by intelligible utterances, but almost entirely of the "word salad" variety. All her spontaneous utterances were disconnected and irrelevant nonsense. She expressed delusional ideas and reacted to hallucinations, constantly attitudinizing in reaction to these. She spent much time listening, interrupting this attitude only to make spontaneous remarks to the person whose voice she imagined she was hearing. Whenever her reverie was interrupted by questions, her reply was composed of irrelevant and wholly irrational statements. Often spontaneous, objectless laughter would occur. She had again reached a stage wherein assaultiveness and destructiveness were frequent, and restraint was often necessary. With this psychotic reaction persisting, while under observation for a period of ten weeks, the diagnosis of SCHIZOPHRENIA of the CATATONIC EXCITEMENT TYPE appeared justified.

The hypoglycemic shock treatment was begun on October 28, 1936, starting with an initial dose of ten units given in the early morning, increasing the dose five to ten units daily. During the first week it required four persons to hold her while the insulin injection was made, or when a blood sugar test was taken, because of her overactivity and assaultiveness. This was a most trying period, indeed, since we withheld hypnotics as much as possible so as not to obscure the results from the insulin therapy. Naturally restraint was necessary for a considerable portion of each day. Gradually, however, the dosage was attained that induced moderate drowsiness, which brought a definite feeling of relief to the physicians and nurses caring for her since she had been so extremely noisy.

When a dosage of seventy-five units was reached, she had a most intense coma reaction preceded by multiple interruptions with expression of psychotic ideas. Yet, the day before she did not go into coma on a dose of seventy units. We considered her shock dose between seventy-one and seventy-five units, therefore, and subsequently found that she would go into an excellent shock reaction on doses of seventy-one to seventy-three units of insulin.

Variable mental states occurred while she was going into coma—sometimes intense weeping for no apparent cause (never noted before insulin therapy was begun), sometimes overactivity would appear for short periods with spontaneous silly laughter on repeated occasions, at other times spontaneous expression of delusional ideas mixed with verbal jargon between periods of peaceful sleep.

About two weeks following the first dose of insulin, the patient had become coöperative at the time the injection was given, though she was still hallucinated both before and after the injection. A few days later she began to have rational periods following her shock treatments, lasting variable lengths of time from one to three hours. As time went on the length of the rational period increased, though her incontinence persisted.

After a period of about ten days in which she seemed quite rational and coöperative each day following her treatments, though still incontinent, there appeared a sudden and apparently complete regression to a state of extreme catatonic excitement. She became assaultive and destructive, and tore up everything in her room; and it required four nurses and a physician to overpower her and administer an H. M. C. hypo which quieted her. This excitement phase, with the loud yelling, singing, and expression of delusional ideas and profane language, mingled with hallucinated periods, then persisted for about a week, in spite of continued shock treatments (extreme regressive phenomena of all kinds occurred—kicking, biting). Gradually,

however, she again became tractable as the shocks were continued daily with a rest day interrupting each week.

From this point on improvement was steady, though infantile behavior tended to persist. The incontinence, for example, persisted another three weeks, and the childish demands continued loud and frequent. After coming out of her daily coma, she would demand most emphatically, "Food, food—give me food—bring me pancakes—pancakes and syrup—bring me cream puffs—lots of them." She would eat them with a voracious appetite. This was most satisfying to her observers, since before treatment she had been refusing food constantly during her ten weeks of custodial, sedative therapy. Now she could not get enough food. This picture is dramatically shown by her weight chart, for she lost twenty-seven pounds in the ten psychotic weeks before treatment was instituted, while in the eleven weeks of treatment she gained forty-six pounds. She now weighs one hundred and ninety-two pounds.

It was possible to allow her to go home, accompanied by her nurse, for Christmas Day. Her family was pleasantly astonished at her normal behavior. She was again allowed at home on New Year's Day, unaccompanied by her nurse. She also behaved well this time. Therapy was continued for another two weeks with decreasing dosage and decreasing periods in coma, though she was not psychotic during that period. There had been no incontinence for three weeks.

She was released from the sanitarium on January 17th, 1937, eleven weeks after hypoglycemic shock therapy had been instituted. She has been seen regularly since, and there has been no evidence of any return of psychotic symptoms. The only thing wrong now is that she has gained so much weight none of her clothes will fit her! It is of interest that this girl has resumed her education, and is now a student in a business school.

CASE II.

A cultured white woman of fifty-four years, married, has a grown daughter who is now married. Onset of psychosis in July, 1936. She became confused and apprehensive over delusional ideas of reference, as well as hallucinatory thoughts, and had to be taken to the sanitarium. For over three months before coming under the care of one of the co-authors, she was constantly delusional and hallucinated, totally lacking insight and had to be guarded constantly by day and night nurses. She came under our care at about the time we started insulin shock therapy with case No. I, and was observed for nearly three weeks before we started the insulin therapy. This treatment was started because of our enthusiasm over the marked improvement then apparent in our first treated case. During this period of observation she was constantly delusional and more or less constantly hallucinated. Facetious laughter often would accompany her recital of the delusions and hallucinations of a given day. The general trend of the false ideas was on paranoid and grandiose planes. She would listen intently to the voices which she believed came through the walls of her room, by a special radio arrangement. Sometimes these hallucinations impelled her to rush out of her room, perhaps downstairs, in an effort to get out to see some person she imagined was outside. She would weave new persons coming into her life into her delusional system. She at once gave the psychiatrist the name of one of her former acquaintances, and continued to call him by this name;—this was a wish fulfilling delusion since she could see a resemblance (in her psychotic mind) between the psychiatrist and the other man. She often carried the delusional fantasy to the extent of proclaiming herself divorced from her husband and about to marry the psychiatrist; that is, she would believe she was about to marry this former friend. In her more delusional periods, the psychiatrist became two men (in her fantasies), both of them former physician acquaintances of hers. In the grandiose sphere, she believed herself to be the Lost Princess Yolande, whom King Edward was seeking, but whom Queen Mary felt wouldn't be a satisfactory queen-wife to Edward because of her age, that is, she was a little too old for him. She frequently was positive that she received messages from both Queen Mary and King Edward in reference to this matter. There were many other delusional and hallucinatory ideas. She had no insight whatever, and was accordingly considered an HEBEPHRENIC TYPE of SCHIZOPHRENIA.

Hypoglycemic shock therapy was started November 15, 1936. Beginning with a dose of ten units, the amount was increased daily until a shock dosage range of forty-five to forty-seven units was determined. On dosage of this level she would become drowsy and gradually somnolent; and ultimately, in one to three hours, would go into a deep coma, sometimes with epileptic manifestations. She would, as a rule, develop that condition which Sakel describes as purporting a good prognosis—namely, the wet shock. Frequently her nightgown and the bed linen would be wringing wet from the profuse perspiration that would occur as she gradually went into coma. After about three weeks on this shock dosage level, the dose had to be increased to a range of fifty to fifty-four units, in order to secure the same results; i. e., deep coma.

Three weeks after this treatment was started, she accepted a visit from her husband—the first in three months. She had told him to get out of her room and never return shortly after she had been brought to the sanitarium (four months before). This was one sphere in which psychotherapy was successful, but subsequent developments would seem to support the belief that this apparent success was merely a false paradise, so far as the ultimate outcome was concerned. In any case, it was about this time that she began to have rational periods, especially during a few hours after her recovery from the insulin coma. Some two weeks later the rational periods appeared to have become permanent. On this encouraging development, it was felt wise to allow her to go home for Christmas Day. She behaved well, returning in the evening. This concession, however, instead of making her better, seemed to disturb her. Therefore, it was felt unwise to let her go home on New Year's Day, as she expressed a desire not to go away until she was perfectly well

and could leave the sanitarium, knowing she need not return.

The hallucinatory reaction had gradually faded into her unconscious, and by December 11th she appeared normal, mentally,—that is, did not express delusions or hallucinations,—and this apparently rational period persisted until January 5th. There were, however, periods of irritability, but no expression of delusions or hallucinations. However, suddenly and without warning, her psychotic reaction broke out anew on January 5th, and on this occasion with its original aggressive, excited, exaggerated, delusional, and hallucinatory reaction. She believed (falsely) that she heard various persons' voices ordering her to do this or that, and she made insistent effort to carry out these telepathic orders.

The treatment has been carried on steadily, but for an interruption of one week in the middle of January (because of possible cardiac complication, which supposition was proven unwarranted by an electrocardiogram). Since resumption, the coma reactions have not proven as satisfactory as when treatment was first instituted. Lately, it has frequently been necessary to interrupt the hyperinsulinism early, because of the onset of convulsive phenomena—and even when these did not appear, satisfactory coma was not being attained. Accordingly, the dosage of insulin was gradually raised to a range of ninety to one hundred units. In this dosage range, a satisfactory coma was attained, occasionally, but this was marred by a severe, convulsive reaction on certain days.

The delusional and hallucinatory reactions, however, have persisted, without insight. It could, perhaps, be stated that the delusions and hallucinations do not have quite as aggressive control of her as they did a month ago, but that is all that can be said. It may be that we are gradually approaching a second recovery phase, but this eventuality seems too good to be true. Although we try to keep an air of optimism, particularly because of the good result (to date) in our first case, nevertheless, we do not feel the outlook is particularly bright for a recovery in this second case. It should be mentioned, however, that there are certain factors which complicate extremely any active attempts at psychotherapy, and it may be that if it were possible to completely change certain life situations, recovery might yet occur in this case. This last, however, is mere conjecture and nothing more.

Since presentation of this paper one month ago, important developments have occurred in case No. II. On February 19th the patient had a severe convulsive seizure while in deep hypoglycemic coma. Dextrose was given intravenously and the usual carbohydrates by mouth. Later the same day, with no further insulin administered, the patient again had a moderate convulsive seizure, and had to be given carbohydrates to counteract this reaction. The following day she had another convulsion during hypoglycemic shock—which again necessitated administration of intravenous dextrose. Insulin treatment was stopped. The patient continued to exhibit mild psychotic phenomena intermittently during the following two days. Thereafter she became rational during the entire day, and developed remarkable insight into the psychotic behavior of the previous months.

At this stage she was for the first time willing to make certain concessions, showing a willingness to discuss the whole situation without losing her temper. Furthermore, she entered into discussions of ways and means of returning to community life—which she had heretofore steadfastly refused to do. She continued rational for another week, and it then was considered advisable to have her return to community life. This was accordingly arranged, and she has remained rational in the community to date (March 17, 1937), a period of three weeks. No regressive phenomena have occurred to date, and there has been noted progressive improvement in her social adjustment.

At the beginning of our study it was decided to keep very complete and accurate records of blood sugar values in relation to insulin dosage and shock. We could find little information on this subject, and felt that perhaps its importance had been overlooked. The technic used was the Folin and Wu method, modified slightly to give more accurate readings of extremely low values.

In general, it must be said that the results obtained were unsatisfactory. Blood sugars were found as low as 10.6 mg. in the first case and 17.8 mg. in the second, yet no definite relation between blood sugar level and degree of insulin shock or dosage could be determined. The results of blood sugar and insulin dosage were graphically recorded, and although the degree of shock could not be charted so accurately, here also the relationship was indefinite. The behavior of the patient on the so-called "shock dose" was totally unpredictable. One day coma or epileptiform seizure resulted, the next day the same dose of insulin apparently had no effect.

In spite of the above findings, we feel that blood sugar estimations should be done frequently, especially in the stage in which the dosage is being rapidly increased. Besides the scientific value of such determination, it gives the physician a valuable check on the rapidity at which the blood sugar is being reduced and may avoid serious or fatal shock from too zealous medication. Patients vary in their initial blood sugar and in their response to a given dose. Blood sugar estimations give an added sense of security and keep us from the

attendant danger and anxiety that come from working entirely in the dark.

Just why blood sugars fail to gauge and predict the patient's behavior is impossible to say. Labbe has suggested that the so-called symptoms of hypoglycemia are not due to hypoglycemia per se, but rather to hyperinsulinism. Since we have no practical method for estimation of the amount of insulin in the blood, we must still rely on blood sugar estimations.

DANGERS

In closing, we jointly wish to emphasize, as have all others in discussing this new method of treatment, the serious dangers involved. Any physician undertaking the treatment of schizophrenia by the hypoglycemic shock method must be in a position to observe the patient constantly, and in a position to meet emergency situations on a moment's notice. Moreover, nursing supervision must be in the hands of adequately trained personnel, for on certain occasions situations may arise in which the nurse must act immediately in accordance with previous orders from the physician. The physician must be at the patient's bedside at least four successive hours daily, and must be available at all times during the twenty-four hours of each day. The nurses must be specially trained for this type of work, and should be as fully informed as the physician with regard to all aspects of the treatment in both the medical and psychiatric spheres. Twenty-four-hour nursing supervision of every case is positively essential.

We would be remiss if we did not mention our sincere appreciation of the painstaking cooperation, even to the most minute detail, of the nurses who have devoted themselves wholeheartedly to this work, and to the Mountainview Rest Sanitarium where our work is being carried on. There were times when the future looked black, and the esprit de corps maintained by all has helped to carry us over the rough spots.

CONCLUSION

With recovery from acute psychotic reactions of such noteworthy degree as has occurred in our first two treated cases, we feel justified in taking an optimistic view of the future of psychiatry. On the basis of the results obtained by others and confirmed by our own cases, it seems clear that vast progress has been made in the treatment for the enigma, schizophrenia. We join with all others in the field in expressing our own appreciation as well as that of our patients',—to Manfred Sakel, who stands out above all others in the field of neuropsychiatry today,—for having pointed the way for others to follow in treating this most perplexing of all mental disorders.

A third case, a young man who has been psychotic for three years, having had three previous periods of institutional care, has recently been placed on the hypoglycemic shock regimé. Treatment has been of too short duration to warrant reporting on this case at this time.

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CERTAIN ASPECTS OF PEPTIC ULCER

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All ulcers called "peptic" have in common the characteristic that they are exposed to the action of gastric juice. They occur more frequently in males, and perhaps in persons of sthenic habitus. They differ from each other, however, in certain interesting particulars.

Incidence.—Peptic ulcers, grouped together, constitute perhaps the most common organic

lesion of the digestive tract, even exceeding demonstrable gall-bladder disease in frequency. In the author's first 4000 private cases, there were 356 "peptic" ulcers, or eigth per cent of all cases, distributed as indicated in table one.

Esophagus	1, or	0.2 per cent
Stomach	49, or	13.8 per cent
Duodenum	296, or	83.3 per cent
Jejunum	9, or	2.5 per cent
Meckel's diverticulum	1, or	0.2 per cent
Total	356	100.0 per cent

Table 1.—Distribution of "Peptic" Ulcers

Sex.—There is an appreciable sex difference when gastric and duodenal ulcers are contrasted. Of the duodenal lesions, 86 per cent were males, whereas of the gastric cases only 75 per cent were males.

Acidity.—A more striking difference exists in the case of the gastric acidity, as shown in table two.

	Per Cent of Cases	
	Gastric Ulcer	Duodenal Ulcer
Achlorhydria	10	0
Subacidity	25	6
Normal Acidity	23	22
Hyperacidity	42	72
Total	100	100

Table 2.—Gastric Acidity in "Peptic" Ulcer

From this it appears that hyperacidity is much more common in duodenal than in gastric lesions; subacidity is rare; and achlorhydria has not been encountered.

Malignant Changes.—The possibility of malignancy must always be considered in dealing with the gastric lesion. In this group during the period covered by this report, three cases with gastric niches proved to be malignant, making an incidence for the entire group of one per cent. No duodenal ulcer proved malignant either in this group or elsewhere in the author's experience.

CLINICAL COURSE

The symptoms of duodenal ulcer are more likely to be sharply defined than those of gastric ulcer. Thus, pain is more regular as to onset, duration, and relief factors. It is my impression that gastric ulcer is more frequently encountered as a surprise finding either at roentgen study, operation, or post-mortem examination than is duodenal ulcer.

As to therapy, bed-rest is more often imposed in gastric ulcer cases, whereas ambulatory treatment is more widely used in duodenal lesions. If surgery is undertaken, a wide resection is more likely to be practiced in the case of gastric lesions because of the ever-present threat of malignancy. Until recently, the most popular operation in the case of duodenal ulcers has been gastroenterostomy, but there seems now to be an increase in the number of resections in cases rebellious to medical treatment.

ATYPICAL ROENTGEN APPEARANCE OF GASTRIC ULCER

The usual roentgen-ray manifestation of gastric ulcer is the classic *niche of Haudek*. There are, however, some cases where the niche is absent and which nevertheless show definite roentgen abnormalities. This has happened six times in the author's series. In five instances, the roentgen picture was similar. In all of these there was considerable narrowing and irregularity of the pyloric end of the stomach, the appearance varying in degree from time to time. In some cases close study showed a rigidity of the affected portion of the lesser curvature with loss of peristalsis. In keeping with the changing picture at different observations, small gastric residues appeared off and on during a series of five-hour observations of the gastric emptying time. On the whole, the appearance was such that carcinoma was strongly suggested. In some of these atypical cases, the differentiation between ulcer and cancer may be made by careful clinical observation with frequent repetition of the roentgen study. If the roentgen appearance remains stationary or improves, and if the clinical picture progresses favorably with disappearance of symptoms, gain in weight, and absence of blood in the stools, watchful waiting is justifiable. Otherwise, especially when repeated roentgen control is unavailable, exploratory operation and even gastric resection is the procedure of choice.

The roentgen appearance that has just been described is in all probability due to a thicken-

ing and scarring of the stomach wall following the healing of an ulcer. In one case, a niche was definitely demonstrated nine years before the author's examination. In another instance, there was a persistent incisura on the greater curvature, which was found at autopsy (death being due to another condition) to have been caused by a large ulcer scar in the pyloric end of the stomach. What is especially interesting is that there had been no history of ulcer in this patient.

Details of four illustrative cases are summarized in the following brief histories:

CASE 1.

Male, forty-four. In 1932 onset of hunger pain. X-ray at that time showed rigidity of lesser curvature, with niche just above incisura, and tubular constriction of the prepyloric portion of the stomach. In 1933 symptoms recurred. Test meal showed achlorhydria, and x-ray showed symmetrical narrowing of prepyloric portion of the stomach, but no delay in emptying. There was no mass. Stools were negative for occult blood, and there was no anemia.

The condition remained about the same with occasional recurrences of pain, but no loss of weight or evidence of bleeding. Two more x-ray studies within the next year showed the same findings. On one occasion there was a very small gastric residue at five hours. Three more Ewald test meals confirmed the achlorhydria, but a histamin test showed that hydrochloric acid could be produced under this stimulus. During the past year, the patient has been free from digestive symptoms. A fourth x-ray examination in March, 1937, showed exactly the same gastric deformity (Fig. 1) and moderate residue. However, the Ewald meal for the first time showed the presence of free acid (free HCl 14; total acidity 34).

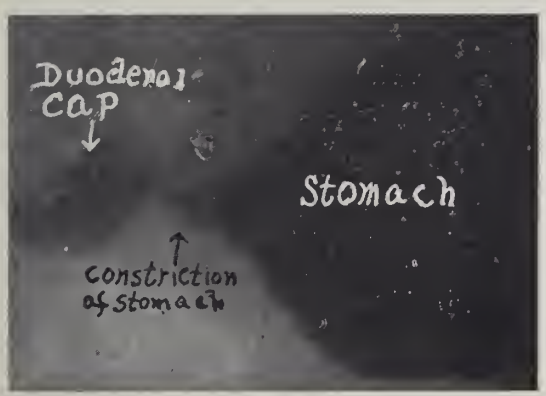


Figure 1.—Prepyloric deformity in Case 1.

CASE 2.

Woman, sixty-two. Seven months' duration of pains in epigastrium and back, coming on three hours after eating. Nausea, anorexia, and waterbrash; three weeks ago vomiting. There was no bleeding. The habitus was sthenic; no mass was felt. X-ray showed prepyloric filling defect, unchanged after atropine. Gastric emptying was undelayed. In view of the age, the recent history, the roentgen findings, and the economic status of the patient, which prohibited prolonged observation, exploratory operation was performed and the distal half of the stomach resected. There was a typical punched out ulcer on the lesser curvature surrounded by a thickened and indurated area. There was no cancer.

CASE 3.

Woman, fifty-five. No previous indigestion. Three weeks ago onset of nausea and belching. Two and one-half weeks ago x-rays showed prepyloric narrowing. The roentgen study was repeated nine days later, after atropinization, with the same result. For one week there was anorexia. The test meal showed achlorhydria. The stools were negative for gross and chemical blood.

In view of the possibility that we were dealing with an early carcinoma, exploratory operation was advised and accepted. At laparotomy, the pyloric end of the stomach was felt to be thickened. The resected specimen showed a definite hypertrophy of the pyloric valve, with the scar of an old ulcer and localized gastritis.

CASE 4.

Physician, fifty. Old history of spastic colon. In 1933 onset of epigastric hunger pains and burning. Physical examination showed very spastic and tender iliac colon; liver just felt; no mass. Test meal: Free HCl 40; total acidity 69 (hyperacidity). Roentgen examination in 1934 showed symmetrical prepyloric narrowing (Fig. 2), but no delay in gastric emptying; also cholelithiasis. In 1935 x-ray examination showed gastric condition unchanged. At the present time (April, 1937) the patient has gained weight and is comfortable on restricted diet, but still has distress when he eats meat.

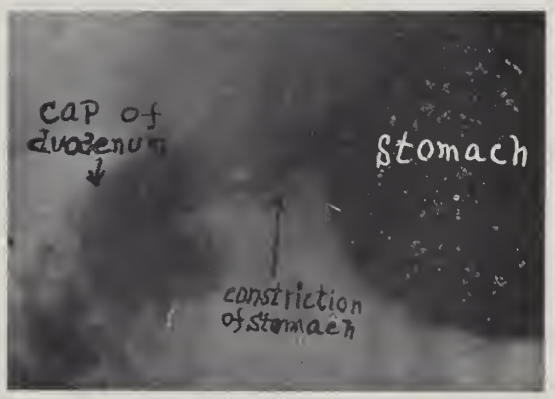


Figure 2.—Prepyloric narrowing in Case 4.

In this case, carcinoma can be excluded by the course of the disease. Whether the roentgen appearance of the stomach is due to an ulcer, an ulcer scar, or spasm secondary to the gall stones, is undetermined as the patient has not yet been explored.

THE TREATMENT OF ULCER

In this section only a few simple principles of ulcer management will be considered. In passing, it may be well to recall that the treatment of ulcer is empiric only, and will remain so until a specific cure is discovered whether or not the cause be discovered also.

REST

First and foremost in treatment comes rest, both physical and emotional. I think it was Bastedo who once said, "If your patient will only get enough sleep, he will have little trouble with his ulcer!" This dictum has led me to think beyond the formal bed rest cure, which is a luxury that not all patients can afford. Besides, no matter how much prolonged, it must end sometime, and the need for rest still continues. Hence, a practical plan to increase bed rest should be of value. This can be accomplished by having the patient go to bed immediately after his evening meal. He will thus spend one whole additional day in bed per week without losing an hour from his business. Moreover, time saved on Sundays and holidays would be additional. If every ulcer patient could but be induced to adopt this procedure as soon as he experiences a recurrence of symptoms, the total morbidity from this disease would undoubtedly be greatly diminished.

Emotional rest, or peace of mind, is even more important than physical. Unfortunately, it is much more difficult to control by the physician. At least, no rules can be laid down, as each case furnishes an individual problem.

FEEDING

Experience teaches that frequent, small, bland feedings relieve the symptoms of ulcer. Beyond this bare statement it is not safe to go, despite the fact that various specific plans of feeding have been recommended on theoretical grounds. If one but reviews the speculative basis for a few of these programs, he will see how slim is their scientific foundation. Let us consider briefly a few well-known examples. Thus Leube might have argued that, since gastric acidity seemed to be harmful, and since proteins called forth the maximum production of acid, it should be reasonable to avoid the use of protein foods. Therefore, he recommended a carbohydrate diet. Lenhartz, on the other hand, may be imagined as pointing out that since it is the protein that binds free hydrochloric acid and renders it innocuous, a high protein diet is therefore indicated. More recently Einhorn thought that gastric irritation could be eliminated by putting food directly into the intestine through a duodenal tube, and this sounded reasonable until it was shown that even under these circumstances there was liberal secretion of acid juice into the stomach.

In short, it is obvious that all these well-known plans of feeding are based on very different and even quite opposed theoretical considerations. Yet, approximately the same therapeutic results are obtained by the exponents of each of these methods. From all of which one must deduce that it is the art and not the theory of the feeding plan that is important.

MILK

Owing to the present popularity of the Sippy diet, milk is a prominent component of ulcer feedings. Milk is cheap, wholesome, universally obtainable, and acceptable to most people. It is not, however, good for everyone, since experience has taught us that milk is particularly ill-borne by persons with unstable or irritable colons. The chief manifestations of this intolerance are gas distress, bowel irregularities, and in many instances actual abdominal pain soon after ingestion. Unfortunately, many individuals are afflicted with colonic instability, and so it is not surprising that some of them suffer from peptic ulcer as well. In the presence of such a combination, milk disagrees either at once or after an interval, when the margin of tolerance has been exhausted. In the latter instance particularly, the sequence of events may be misunderstood, and milk is continued in an effort to relieve the very symptoms it causes.

The diagnosis of colonic instability is made from the history, stool inspection, and most precisely, by roentgen study of the bowel function. The diagnosis of milk intolerance is made by the simple therapeutic test of milk withdrawal. To replace the milk of the intermediate

feedings, gruels made with water may be used, or dry foods such as crackers with butter or cream cheese, or small sandwiches.

The writer has seen many ulcer patients, including a fair number of physicians, who have suffered unknowingly from milk intolerance for months and years. The more pain they had, the more milk they drank, so that they had become, as a rule, fat, pasty-looking, very gassy, and wholly miserable. Their relief was equalled only by their surprise when they were abruptly weaned and allowed to partake of steaks, chops, seafood and an occasional glass of beer as a final gesture of emancipation.

The following case histories are illustrative:

CASE 5.

Physician, thirty-eight. Always tendency to constipation; in past four years three attacks of diarrhea, each lasting four to five days. Nine years ago onset of attacks of epigastric hunger pain. At that time definite niche seen on lesser curvature of stomach. This disappeared and has not recurred despite annual x-ray examinations. Symptoms, however, have persisted with no free interval exceeding four weeks. Nine years ago patient began milk diet, taking three glasses of milk every day. His weight at that time was 180 pounds (ideal weight 164 pounds). When seen on March 11, he weighed 200 pounds.

The current attack was of four months' duration. The pain was described as more severe than ever before. It came on two hours after meals, was located in the epigastrium, and radiated to the back and left loin. Food and alkalies gave only incomplete relief. The bowels were constipated, and there was much distention. Sharp pains in the right upper quadrant were relieved by gas passage. For two weeks the patient had been taking two and one-half quarts of milk daily.

Treatment consisted of the withdrawal of milk, and substitution of an ordinary balanced diet. One week later the pains were less severe. Three weeks later the pains were practically eliminated. Two months later (April, 1937) the patient has had the longest free interval in nine years.

CASE 6.

Male, forty-nine. Typical ulcer history for five years with positive x-ray findings. When first seen by the writer, the patient had been suffering again for two months. Instead of the usual epigastric hunger pains, the pains were located in the lower abdomen, especially in the left lower quadrant, in the back below, and up around the rib margins. As in the previous case, they were more severe than in former attacks, shifted in their location, and were accompanied by increased flatulence. The diet included one glass of milk for breakfast, at 10 a. m., at lunch, at 4 p. m., at supper, and at 10 p. m. Despite these findings, the patient was twenty pounds underweight. X-ray examination confirmed the presence of a duodenal ulcer, and revealed a very irritable colon (barium to rectum at nine hours; total colon capacity only 28 oz. after opaque enema).

The treatment consisted of a mild sedative mixture, no alkalies, and Schmidt diet without milk. Within one week the pains were diminished. In one month, the patient was symptom free. In three months he had gained eight pounds.

In short, it seems fair to conclude that there must be a considerable number of patients with healed ulcers whose persistent symptoms are due to nothing but a continuation of milk diet. To these, however, must be added still another group of individuals in whom ulcer had been erroneously diagnosed, and for whom milk had been prescribed with similar consequences.

DRUG TREATMENT

There is no known drug treatment for ulcer as such. Antacids, and particularly alkalies (which are not quite the same thing) may usually be relied upon to relieve pain if this is not adequately controlled by frequent feedings. This is fortunate because the ulcer patient is thus spared the use of anodynes, which are often unavoidable in pain due to other causes. But the amount of alkalies required to relieve actual ulcer pain is small indeed compared to the gargantuan doses that have been prescribed for the pseudo-scientific reason of completely neutralizing gastric acidity. As far as I know, it still remains to be proven that ulcers *in man* heal more kindly in the absence of acid. Be that as it may, it can be shown by anyone who takes the trouble to do so that, as an ulcer heals, the test meal figures do not always diminish. On the contrary, they may even be higher after healing than they were during the period of ulcer activity. Furthermore, as shown earlier in this paper, 10 per cent of gastric ulcers occur in the absence of hydrochloric acid. Finally, the administration of alkalies instead of stopping, actually increases acid production. But what is more important than theory is the simple fact that an excess of zeal in alkalinization has been known to bring on systemic mischief in the form of alkalosis. This, of course, can hardly be expected to benefit the local digestive lesion with which the patient started. It is much bet-

ter, indeed, to reverse the procedure and apply the old rule of the minimal effective dose. When this is done, it will be found that a great many patients will get well with no medication whatever.

Finally, a few words about drugs that have been advised for the healing of the ulcer. When the writer began the practice of medicine a quarter of a century ago, it seemed that every text-book dealing with ulcer advocated the use of silver nitrate. I have forgotten the exact basis for this recommendation, but no doubt the drug was thought to have a healing influence. Today, one hardly ever hears of this form of therapy. Yet new drugs and procedures are constantly being proposed "because they heal the lesion." Some years ago it was foreign protein injections; then it was mucin; more recently it is histidin,—all recommended on the basis of either animal experiments or clinical evidence. As for animal experiments, not only is it always risky to transfer conclusions from animals to the case of man, but in this instance one must be doubly cautious because animals do not develop ulcers spontaneously as do human beings, but only as the result of procedures that do not apply at all in the case of mankind. Clinical evidence is of course impressive when it is significant, but clinical evidence that is wholly uncontrolled can hardly be given serious consideration. Unfortunately, many of the drugs are recommended without careful control studies. As soon as these are made, it is discovered that a real medicinal cure for ulcer is still wanting. Let us hope that the solution of the problem is not far distant.

SUMMARY

1. The chief differences between duodenal and gastric ulcers are that the duodenal are more common, occur more often in males, are associated with higher ranges of gastric acidity, and do not degenerate into carcinoma.

2. Gastric ulcers may occasionally exhibit atypical roentgen appearances resembling cancer. Under such circumstances, great watchfulness should be practiced, and early exploration should be performed in all doubtful cases.

3. In the present stage of our knowledge, ulcer therapy is empiric rather than specific. One should therefore not be misled by claims for therapeutic procedures which are based on purely speculative reasoning.

4. Excessive milk is harmful in "colitis" cases. When ulcer cases are associated with colonic instability, good results may follow the complete withdrawal of milk from the diet.

5. Over-alkalinization is unnecessary and may be harmful. Alkalies should be used to control symptoms rather than to neutralize acidity.

6. There are no drugs that are known to heal ulcers, despite the fact that many are constantly being recommended on the basis of animal experiments or uncontrolled clinical experience.

DISCUSSION BY SIGURD W. JOHNSEN, M.D., PASSAIC

Dr. Kantor has clearly shown in his paper that peptic ulcer is a complex problem, to which there are many avenues of approach. This leads to the conclusion that we are far from knowing the etiological factor or factors in the production of this baffling disease. However, when we have a clearer understanding of the various phases of the problem, we can hope for a solution of its etiology.

The old question of the relationship of gastric ulcer to carcinoma keeps coming up continually. The earlier we make our diagnosis, the greater is the difficulty in differentiating between the two lesions. Repeated examination with the patient under thorough therapeutic control should settle the diagnosis.

There are many cases which seem to me to be particularly worthy of intense study. These are the cases in which we cannot demonstrate any definite pathology, but in which we have the characteristic ulcer picture, namely, increased gastric acidity, gastric and colonic hypermotility, and the worried type of disposition. In these cases I fully believe we have a true pre-ulcerous condition. They should be treated as ulcer patients and thus avoid the later complications of ulcer.

Another topic which Dr. Kantor has not mentioned is the complication of ulcer by another disease. It is commonly accepted as a fact that, if the ulcer patient does not lose his pain on an adequate ulcer therapeutic regime, look for another explanation. However, I have recently had three cases of proved duodenal ulcer with recurrence of ulcer activity while on a strict ulcer regime, and have then found a complicating diabetes. When the diabetic condition is brought under control, the ulcer therapy again becomes effective.

I am very glad that Dr. Kantor spoke on the many facilities for ulcer therapy. There is a new treatment for ulcer almost every month, and this is bewildering to many who are trying to render their ulcer patients the best of care. I believe with Dr. Kantor that the basis of ulcer therapy should be dietetic and individual.

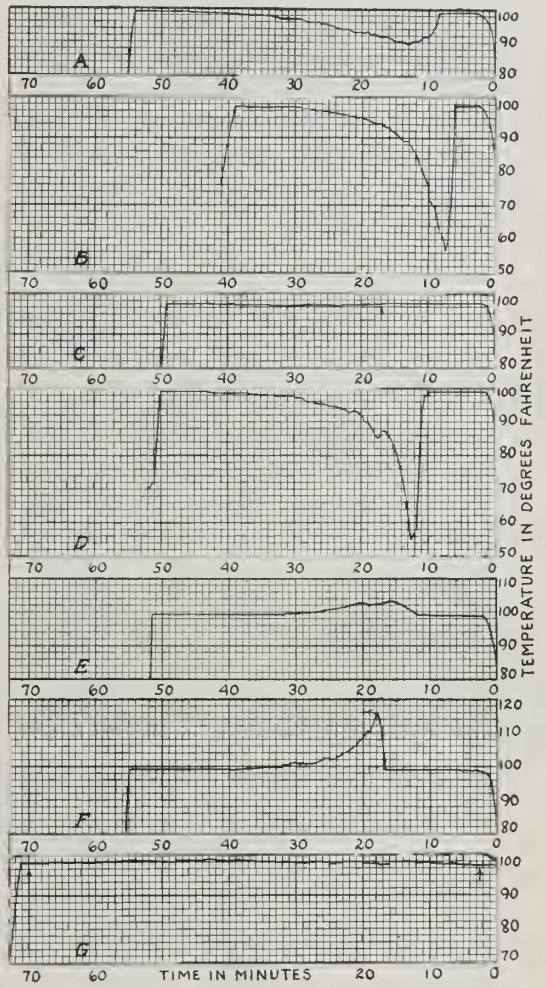
STUDIES OF GASTRO-INTESTINAL TEMPERATURE

By Joseph S. Hepburn, M.D., Ph.D., and
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From the Departments of Chemistry and Gastroenterology of The Hahnemann Medical College and Hospital of Philadelphia. Read before the Atlantic County Medical Society, February 12, 1937.

This research was conducted by the authors with the collaboration of Drs. Rowland Ricketts and Charles L. W. Rieger, and the technic and results were published in detail in the *Archives of Internal Medicine,* 1933, LII, 603-615. Temperatures were measured by means of an especially constructed resistance thermometer of insulated nickel wire mounted in a silver tube one inch long and one-quarter inch outside diameter. Temperatures were recorded automatically by a resistance thermometer recorder which was constructed on the principle of the Wheatstone bridge. The thermometer was connected with the recorder by insulated copper wires which were contained in a flexible rubber tube approximately one-fourth inch in external diameter. This rubber tube was cemented to the proximal end of the silver tube. The current for the thermometer circuit was supplied by two dry cells. Under the conditions of these experiments, the conductivity of the nickel wire of the thermometer changed markedly with changes in the temperature of its immediate environment, while the conductivity of the copper wire remained unaltered. This change in the conductivity of the thermometer immediately affected the equilibrium of the Wheatstone bridge, and was recorded by the recorder on a graph which was graduated in degrees Fahrenheit. The recorder was operated by an electric motor connected with the house current.

For measurement of the gastric temperature, the thermometer was introduced in the same manner as a stomach tube. For measurement of the temperature of the upper portion of the intestine, the thermometer was introduced in the same manner as a duodenal tube for non-surgical biliary drainage. Oral temperature was measured with a clinical thermometer. The subjects were healthy, active individuals, chiefly technicians and students in the schools of medicine and nursing, and were in the postabsorptive state at the beginning of each experiment.



Changes in visceral temperature. Each graph is read from right to left. A rise in temperature at the right margin is due to swallowing. Graphs A to F record gastric temperature; graph G, duodenal temperature.

Graph A records the minimum observed effect of ice water; graph B, the maximum observed effect of ice water.

Graph C, the minimum observed effect of ice cream (the arrow denotes beginning of ingestion). Graph D, the maximum observed effect of ice cream.

Graph E, the minimum observed effect of hot coffee. Graph F, the maximum observed effect of hot coffee.

Graph G, the maximum observed effect of any form of physical therapy. Diathermy was applied during the period between the arrows.

In the experiments with ice water, ice cream, and coffee, the subjects were in a sitting position. In all other experiments on the stomach and the upper part of the intestine, the subjects were in a supine position. Roentgenography was used to determine the actual position of the stomach in all experiments concerning the influence of physical therapeutic agents upon gastric temperature, and also to determine the position of the thermometer in the intestine in all experiments upon the temperature of the intestine and the effect thereon of physical therapeutic agents.

GASTRIC AND ORAL TEMPERATURES

The measurements of gastric temperature in 129 men and 128 women are summarized in table one; and the deviation of gastric temperature from oral temperature in these subjects is sumarized in table two. In forty subjects, during periods of 0.5 to 3.5 hours, gastric temperature variations as great as 3.8° F. were noted. The temperature of the upper intestine (duodenum and jejunum) was between 98.0° and 100.1° with an average of 99.1° F. in thirty-four men; and between 98.0° and 99.9° with an average of 98.9° F. in nineteen women. The temperature of the sigmoid was measured in three men and three women by introduction of the resistance thermometer through a sigmoidoscope well past the sphincter of O'Beirne; the temperature was between 100.8° and 101.5° with an average of 101.2° F., and was 2.0° to 3.5° higher than the oral temperature.

Table 1.—*Gastric Temperature*

Temperature, F.	Men	Women
97- 97.9	3	1
98- 98.9	28	21
99- 99.9	76	77
100-100.9	20	21
101-101.9	2	7
102-102.9	0	1

Table 2.—*Deviation of Gastric Temperature from Oral Temperature*

Deviation, F.	Men, per Cent	Women, per Cent
—0.1 to —0.9	8.06	3.13
0	4.84	2.34
0.1 to 0.9	40.32	35.16
1.0 to 1.9	36.29	41.41
2.0 to 2.9	9.68	14.06
3.0 to 3.9	0.81	3.13
4.0 to 4.9	0	0.78

EFFECT OF ICES

The effect of ice water and ice cream on gastric temperature is summarized in table three. The ice water (250 cc.) and the ice cream (90 grams) were ingested in separate experiments as rapidly as possible without discomfort. Their temperature was measured with a mercury thermometer, and the time required for ingestion was measured with a stop watch. It will be noted that, on the average, the stomach required between thirty and forty minutes to return to its initial temperature after ingestion of one of these cold foods. The gastric temperature underwent an immediate marked decrease, followed by a rise, at first quite rapid, then progressively slower. When a constant temperature was again attained, it tended to be a few tenths (on the average 0.2) degree lower than the initial temperature. It may be added that use of ice water in a test meal delayed the gastric emptying time by from fifteen to thirty minutes. Evidence was also obtained that leakage of a cold beverage through the pylorus lowers the temperature of the upper part of the intestine by several degrees; this observation may explain the etiology of gastroenteric disturbances in patients who have a rapid gastric emptying time, and partake copiously of cold beverages.

EFFECT OF HOT DRINKS

A series of eleven experiments was made with hot coffee. Ingestion produced an immediate marked increase in gastric temperature, followed by a decrease, at first rapid then progressively slower, until a constant value was attained. The increase was between 4.2° and 17.0° F.; the recovery time was between 19.9 and 45.0 minutes; the final temperature tended to be 0.1° F. higher than the initial.

Study was also made of the possible effect upon visceral temperature of physical therapeutic agents (electric pad, hot water bag, infra-red lamp, diathermy, hot wet pack, ice bag) applied over either the stomach or the upper part of the intestine, usually for an hour

TABLE 3.—*Effect of Ice Water and Ice Cream on the Gastric Temperature*

Substance Ingested	Observation	Sex	Maximum	Minimum	Average
Ice water	Temperature of ingested ice water, F.	Male	40.1	32.5	34.0
		Female	34.7	32.9	33.4
	Ingestion time, minutes	Male	1.12	0.11	0.33
		Female	1.35	0.21	0.59
	Decrease in gastric temperature, F.	Male	37.9	9.8	27.6
		Female	42.5	7.2	22.9
	Recovery time, minutes	Male	62.0	10.2	38.1
		Female	65.1	25.6	39.8
Ice cream	Temperature of ingested ice cream, F.	Male	23.0	—0.4	9.5
		Female	27.5	—0.4	7.7
	Ingestion time, minutes	Male	6.02	1.50	3.24
		Female	8.50	1.96	4.30
	Decrease in gastric temperature, F.	Male	43.8	1.0	8.3
		Female	14.9	0.2	5.1
	Recovery time, minutes	Male	52.8	11.5	32.6
		Female	57.0	20.0	36.1

or longer. None of the observed changes in visceral temperature exceeded the maximum variation in gastric temperature during similar periods of time in a control series.

The application of heat to the abdomen produces a feeling of comfort when localized or general pain exists. However, in view of the results in this research, the production of any reparative benefit by local application of heat or cold is conjectural. It is doubtful that the benefit obtained is sufficient to warrant subjecting the patient to the various local applications of heat, especially in Summer. Consultation with several physiologists has not yielded any explanation of the process resulting in the feeling of comfort. The results also render debatable the use of ice locally for the control of gastric or intestinal hemorrhage, and the local application of heat to promote the healing of gastric or duodenal ulcer.

THE USE OF CHEMICALLY PURE SYNETHETIC ALLANTOIN IN THE TREATMENT OF OSTEOMYELITIS

By A. R. COMUNALE, M.D., Rahway, N. J.

Read before the Medical Staff of the Rahway Memorial Hospital in June, 1937

Allantoin is an oxidation product of uric acid. In vivo the enzyme uricase, with oxygen and water, act on the purine base 2-6-8 trioxypurine or uric acid, to form natural allantoin. It is the end product of purine metabolism. Although widely distributed, it is found in human urine in only small amounts (5-15 mgs per day).[1]

In 1932 Livingston and Prince[2,3] obtained a saline extraction of whole maggots, which was used on 200 cases of osteomyelitis; and in 1936 Livingston reported its use on 567 cases of chronic metastatic and traumatic pyogenic osteomyelitis.[4] The chemical analysis of the maggot extract was found to contain among the other radicals, natural allantoin.[5] However, Livingston's conclusions are that the effectiveness of maggot therapy is due to stimulation of tissue regeneration attributed to a combination of all the substances, viz., sulphydryl (S. H.), natural allantoin, calcium, cysteine, glutathione, and in addition embryonic growth-stimulating substances.

CASE REPORT

Mrs. A. G. was seen on January 26, 1937, complaining with excruciating pain at the tip of the left thumb. For the past two years she

has been treated for diabetes mellitus; arteriosclerosis with hypertension, and chronic myocardial degeneration. Her husband died of heart disease. She has two healthy daughters, and one in an institution for the mentally ill. Several members of her family also have diabetes mellitus.

Physical examination reveals a thin, white elderly female, seventy-three years of age, weighing about 100 pounds. Temperature normal, blood pressure 180/100. Vision is poor and wears glasses, but pupils react to light and accommodation. Teeth have been extracted at an early age. No abnormality or obstruction found in the nose or ears. Hearing is good. No lymph-glandular enlargement is present about the neck. Expansion of the chest is good and equal, and the breasts are also negative for masses. A few scattered râles are present, but of no significance. The heart is normal in size, apex beat is heard in the seventh intercostal space and three inches from the border of the sternum. The sounds are of poor quality, and irregular rhythm, but no murmurs. The liver, kidneys, spleen are not palpable, and there is no tenderness or rigidity of the abdomen. No hernias are present. The skin is dry and a tendency to scaling. The reflexes are normal.

The left thumb, when first observed, was acutely tender to palpation, with swelling and redness extending to the base of the thumb. It had been acutely inflammed for about a week; the exciting cause was a small hangnail infection on the medial aspect. A small incision with local anaesthesia was made on January 26, 1937, and hot chlorazene wet packs applied. Dressings were changed daily, but drainage was apparently insufficient. On February 1, 1937, the pain was very severe, requiring an opiate (pantopon gr. 1/6 q. 4 h).

A deep incision was made on the medial aspect of the thumb about one inch in length down to the necrotic distal phalanx. Another small one was made on the lateral side. The local anaesthesia was produced by injecting a two per cent solution of procaine borate and epinephrine (Searle) in a circular manner at the base of the thumb. Approximately five cc. of this solution was required to anaesthetize the volar interosseous branch of the median nerve which sends collaterals to the muscles of the ball of the thumb, and the dorsal digital nerve from the superficial branch of the radial nerve which supplies the integument on the dorsal aspect of the last phalanx.

The tendon sheath of the flexor pollicis longus was incised also. A thick, dirty, greenish, foul, suppurating fluid was freed.

Hot chlorazene wet packs were continued, but on February 5, 1937, the back of the hand became swollen, despite good drainage. The next day an x-ray was taken to determine the extent of the osteomyelitis. The two views showed that approximately two-thirds of the distal phalanx was involved. The urine, however, was and had been sugar free.

A 0.4 per cent solution of allantoin was prepared by dissolving 20 gr. of crystalline powdered allantoin in one pint of hot distilled water. By means of a genito-urinary irrigating glass syringe with a blunt tip, the wound was irrigated on the medial side, and then on the lateral side; and following this, some of the solution was purposely forced into the tendon sheath of the flexor pollicis longus, and a wet pack of the same solution applied.

The next morning, February 11, 1937, a fluctuating area situated between the base of the thumb and the index finger was opened on slight pressure by an ordinary hemostat, and a thin, yellow, purulent fluid flowed out freely. The sinus was gently washed out with the allantoin solution, after which a small quantity was forced at this point, allowing it to evacuate itself at the two incisions at the tip of the thumb.

By February 13, 1937, a very marked improvement was observed. The swelling of the hand and thumb was markedly decreased, drainage was satisfactory, and no odor could be detected about the wound or dressings. The irrigations and wet packs of allantoin solution were continued daily up to February 20, 1937. A thick, white mass of adherent necrotic tissue failed to separate from the healthy tissue. A five per cent unguentum of allantoin in equal parts of lanolin and white petrolatum was packed into the cavity, and sterile dressings were applied. Dressings were changed on February 22, February 24, and on February 26

the entire necrotic mass was easily lifted out of the cavity with a hemostate, and there remained a clear, clean, healthy, red granulating surface without bleeding. Two per cent mercurochrome was instilled, and sterile dressings were applied. An x-ray check-up, made on February 28, 1937, showed the distal phalanx to be in good condition and the osteomyelitic process to have improved. On March 6, 1937, the patient was discharged as cured.

RESULTS

1. When allantoin is used as a 0.4 per cent solution, the drainage is copious, thin, yellow without odor.
2. The drainage resembles that which occurs when maggots are used.
3. The edges of the healing wound are similar to that occurring with maggot therapy.
4. A quicker, natural debridement seems to occur when allantoin is applied as an unguentum into the cavity.

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DISCUSSION

Dr. J. M. Carlisle stated that some physicians were using urea crystals in the treatment of osteomyelitis and obtaining the same results as found in allantoin therapy. He also stated that urea is somewhat less expensive than allantoin.

Dr. Joseph S. Mark stated that, when using urea in one of his own cases, he found that the dressings had a very objectionable uriniferous odor in a few hours which is repulsive to both the physician and the patient—and that in his own practice he much preferred treatment with allantoin and found his results very satisfactory.

Dr. Comunale, in his summary, made the following comparison between maggot and allantoin therapy: (a) A fine meshed cage must be prepared for the maggots; (b) they must be implanted twenty-four to forty-eight hours after being obtained from laboratory; (c) they are repulsive to both the physician and patient; (d) they need wide incision of wound, and must have either natural or artificial light; (e) must be washed out at the end of five or six days with saline, as they reach maturity and die in their own excretions; (f) no antiseptics can be applied when implanting maggots.

Allantoin (a) can be obtained chemically pure, free of objectionable substances and the ever-present possibility of tetanus organisms; (b) can be used in hematogenous, acute, or chronic, osteomyelitis as a wet dressing, instillation or ointment pack; (c) is the active principle which maggots excrete, and can be placed in the wound for longer intervals.

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THE CORRECT TECHNIC IN ELECTRO-COAGULATION OF THE CERVIX, AND ITS ATTENDING DANGERS

MATERNAL WELFARE ARTICLE NUMBER TWENTY

By INGLIS F. FROST, M.D., F.A.C.S., Morristown, N. J.

There is little doubt as to the prevalence of endocervicitis, and it is, without question, one of the most common of all the pathological conditions associated with the uterus. While cervical erosions and infections are most frequently found in the multiparae, endocervicitis is not by any means confined to this group, but may occur in both the virgin and the nullipara.

It is a curious fact that medical men, in general, have been slow to realize the importance of the cervix as a potent focus of infection, and have been prone to neglect it in so far as its treatment is concerned. Such conditions as salpingitis, pyelonephritis, peremetritis, and metritis may be the result of a cervical infection.

There is also, according to most observers, a definite relationship between the chronically infected cervix and cervical carcinoma. This deduction is based on the fact that cervical carcinoma has a higher frequency in women who have borne children than in those who have not. It would seem, therefore, that the rôle of pregnancy may be a predisposing factor.

POST PARTUM EXAMINATIONS

It has only been in recent years that obstetrical departments and maternity clinics have realized the absolute necessity of instituting a rigid follow-up service of the post partum cervix; and it is now the rule in many clinics that the patient shall not be discharged until the cervix is thoroughly healed.

Barret in 1934 reported a series of 120 cases of cervical disease treated at the Woman's Hospital, and found that about 50 per cent of their delivered cases needed treatment of the cervix in the late puerperium.

In an effort to ascertain how these figures compared with other maternity clinics, and also to obtain a percentage estimate as to the prevalence of cervical disease, a questionnaire was sent to about five hundred obstetricians and gynecologists in this and other countries. The percentage of the figures submitted in the returned questionnaires showed a remarkable consistency, and compared closely with those reported from the Woman's Hospital.

Also in our questionnaire was a query as to the type of treatment used in the various clinics,—that is whether they preferred a chemical application, actual cautery, electro-surgery, or an operative procedure.

ELECTRO-COAGULATION

It is not my purpose to discuss the relative merits of the various forms of treatment; however, I do feel that electro-surgery is making rapid strides, and that if it is used judiciously and intelligently, it presents a mode of treatment that is superior to all others.

Like many things that are new, however, there are the enthusiasts who feel that now all things are made easy; and so they proceed to use electro-surgery without careful thought, and without the proper training for such work.

It is much like history of the rectoscope in prostatic work, where men who were untrained in this special field of work, and who were unfamiliar with this instrument, attempted to perform prostatic resections. Naturally, bad results followed, and with them a condemnation of a type of treatment which in expert hands has proved itself a blessing.

Recently there has been a surge of machines on the market which combine diathermy with short-wave therapy, and due to the ever effervescent high-pressure salesman, these machines have found their way into the hands of many men who have not had the necessary training in their use.

The salesman, in most cases, has assumed the rôle of the professor of surgical therapy, and technical director, and many times is neither a physician nor a trained technician, but one who has learned the knack of cleverly cutting figure eights, loops, and spirals from a piece of frozen meat. Not long ago I watched such a demonstration and marveled at the dexterity with which the salesman sectioned the fronzen specimen and coagulated other areas with neatness and precision; but as deftly as he worked, it was impressed upon me, as to what a vast difference there is between the coagulation of meat and the delicate tissues of the cervical canal.

CAUSES AND KINDS OF EROSIONS

It has been my experience that most machines coagulate too fast, and much too severely; and unless the minimum amount of current is used, severe carbonization and sloughing will occur.

Laceration and trauma are probably the biggest factors in producing cervical infections. The inflammatory reaction is accompanied by a maceration and desquamation of the epidermoid cells. These cells, in the process of healing, are replaced by columnar endocervical mucus-secreting cells. This replacement forms the common *erosion,* and in the shift of columnar to squamous cells, the *Nabothian cyst* is formed. As bacterial invasion takes place, many of the cells of the racemose glands are destroyed, thus giving rise to a mucopurlent discharge.

Various forms of pathological cervices are encountered in the routine treatment of endotrachelitis. These may be cited as follows: First, and probably the simplest conditions, are the so-called *pseudo erosion* which is most often seen in the virgin; the more advanced erosions, with or without infection, which frequently follows partuition; the lacerated, hypertrophied, everted cervix, often odematous

as well; the single or multiple cystic cervix; the endocervical infected canal, with its thick and muco purulent discharge; and lastly, the cervix with polypoid growths.

Each of these conditions needs its own special type of coagulation, and should be treated only after a careful study of the pathology present.

Before proceeding to any treatment, a careful pelvic examination should be made to ascertain the possible presence of tubal infection; and if there is suspicion of such an infection, coagulation should be deferred as there is the greatest danger of exciting an acute pelvic inflammation.

Following the pelvic examination, a thorough inspection of the cervix is indicated to note the possible presence of leukoplakia areas; and if present, to ascertain whether they are false, or beginning carcinomatous areas. These may be visualized by the use of Lugol's solution, which forms a contrast of the stained and non-stained areas. This solution should be used as part of the routine examination, and may either be swabbed or sprayed over the surface of the cervix.

In the removal of leukoplakia areas for examination, it is better judgment to use a sharp bistoury, and not the cutting current, as this will tend to destroy the cells and make the specimen useless for examination. Also at the time of cervical inspection, one should judge the type of treatment best suited to the pathological condition that is present.

It is important not to coagulate too near a menstrual period. It should be performed always after the first week following the period, and never later than five days prior to the next.

If the cervical infection is acute, coagulation should be deferred until all signs of the acute inflammation have disappeared.

In dealing with a combined infection of the canal and the portio, a better practice is to first coagulate the canal, leaving the portio—the protruding part of the cervix—until a later date. It will be noticed that in about ten days the portio erosion will be much reduced and with much less infection present. There is a further advantage in that the inflammatory products will not lend to plug the canal, which they are apt to do if the portio is coagulated first.

Some patients are extremely sensitive to coagulation, and may need a local anesthetic applied to the canal and the portio before the treatment takes place.

Every patient should be warned that they may have a profuse watery discharge for about ten days. A bicarbonate of soda douch will do much to help this and remove offensive odors.

The presence of a thick muco-purulent plug may make coagulation of the canal a difficult problem, as its presence makes it hard to obtain a satisfactory coagulum. Either cariod powder, or sodium per borate slightly moistened, will aid in cleansing and removing the plug of mucus from the canal.

Before proceeding to coagulate the cervical canal, an estimation should be made as to its length, the amount of infection present, and the distance that the infection extends upwards. A small ear curette will give this desired information. In curetting the canal, one will often get the feeling of roughness, or, as Dickinson so well describes it, the sensation of scratching the back of linoleum or a Brussels carpet. The small curettings may also produce necrotic tissue from the infected racemose glands.

Coagulation of the canal must be thorough so as to destroy all the infected glands and thus obtain complete healing.

METHODS

Electro-surgery offers two methods of attack in the treatment of the cervix,—one is by means of the cutting current exemplified by the Hyams conization method, and the other by means of coagulation.

Conization, by means of the cutting current, removes the necrotic area from the canal, while coagulation depends, for its action, on its thermal penetration, thereby causing a thrombosis of the vessels and a necrosis of the proliferating cells. There is also a dehydration of the tissues and a sterilization which extends beyond and deeper than the visible coagulated area.

There are two types of thermal units which may be used in coagulation,—one is the spark

gap, and the other the newer radio tube machine. Either one gives equally good results, but they vary from each other in their action and mode of application.

In using the spark-gap machine it is absolutely essential to operate with the lowest possible voltage; and this should be, on most machines, about 110 volts, and should never exceed 400 volts. The spark gap should barely be open and hardly audible, and the milliamperage should register not more than 600 milliamperes at any time during the operation.

The short-wave machine is more constant and smoother in its current, and perhaps easier to control; but because of the speed of its oscillations, it causes carbonization more readily than the spark-gap machine, unless a great deal of care is used in its operation. It is essential to start with the current at its minimum and work upwards from that point.

The usual procedure in coagulating with either the spark-gap or tube machine is to place the negative pole under the patient, or attach it to the arm, while the positive electrode is carried to the patient, usually by means of a ball contained in an applicator handle.

Another means of coagulation is by the combination of both electrodes in one applictor, such as the Cherry Ende, or the Wilimac applicator. This type of applicator has distinct advantages in that it is faster of application, causes less pain, and is more accurate in its treatment of the canal.

It must be borne in mind that, with a plate under the patient, the current passes from the point of the positive pole to every point of the negative electrode, and therefore causes more current to pass through the patient's body than a current which merely passes over the shorter distance of the two poles contained in the one applicator; and therefore the latter is the less painful operation.

In applying the applicator to the eroded surfaces, the lightest possible contact is all that is necessary, and the color to be obtained is a creamy white; beyond this color is a yellow which must be avoided, since it means that carbonization is taking place, and, if continued, sloughing and necrosis of tissue will follow.

Much can be accomplished in the large odematous, ectropic cervix by coagulating radial lines from the center to the periphery. This will reduce the edema, and, as healing takes place, it will help to form a well-molded cervix.

Cysts can be punctured and their bases coagulated, so that no scar tissue is present after healing.

In dealing with the canal a great deal of care should be exercised with the use of the ball electrode, since carbonization can easily take place, as it is difficult to gauge the coagulation evenly. Some form of applicator with only one side exposed is preferable, as it gives a more controlled and an even thermal application to all parts of the canal.

I should like to emphasize that the *minimum* amount of current is all that is needed at any time, and that the color that should be produced is the described creamy white. In purchasing a machine, one should be sure that it will give the minimum amount of current to produce the above color.

Several times in coagulating I have had patients call me about ten days later to tell me that they are bleeding, and on examination I have found a slough which could be removed by forceps. This means that they were coagulated too severely; and that carbonization took place, and not coagulation.

Coagulation, if carefully performed, produces no scar formation, and the healed result conforms very closely to the original normal cervix.

In our effort to eradicate endocervicitis, every effort should be made to deal with this condition intelligently and thoroughly. A cervical examination should be made of every patient that seeks relief from a leukorrhea discharge.

Coagulation offers us a safe and thorough mode of treatment, and by its careful use in the trained practitioner's hands, will restore damaged cervices to a normal and healed condition.

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SCIENTIFIC EXHIBIT NUMBER FORTY

EXPERIMENTAL RADIUM POISONING

By Maurice Rosenthal, M.D., and Edwin G. Grace, M.D.
Long Island College of Medicine, Brooklyn, N. Y.

The exhibit comprised the concrete evidences from which the following conclusions were deduced:

Our experimental studies, conducted over a period of several years, have indicated that the effects in rabbits of the administration of radium sulphate per os may be summarized as follows: Gingivitis, alopecia, abrasion of teeth, necrosis of bone, spontaneous fractures, regenerative anemia, and hyperplasia and fibrosis of bone marrow. Similar changes, and in addition osteogenic sarcoma, have been reported in human cases. It is also of interest to note that in our experimental animals as in the human cases the first changes were observed in the jaw and mouth, a condition for which no satisfactory explanation has as yet been advanced. Martland stresses the importance of mesothorium in the production of the extensive jaw necroses, and also of the severe anemias in the early acute cases among the radium-dial painters. Our experiments show that changes of a similar nature can be produced by sufficient quantities of radium alone.

Of particular interest are the changes in the blood-forming tissues in our experiments, since the administration of the radium by mouth was followed by lesions which resemble closely the changes that have been observed in human cases. Our observations would seem to indicate that in the bone marrow, radium poisoning produces at first a stimulation of the cells of the erythroblastic series with a preponderance of normoblasts, an effect which is to some extent reflected in the blood picture of this period. Continued action of the radium inhibits maturation of the erythroblasts, as evidenced by a slight increase in the number of erythroblasts despite a decided decrease in the total bone marrow erythrocytic elements. At this stage there is an extensive replacement of erythroid elements by cells of the granulocytic series, with the production of the picture of the so-called "replacement anemia".

It is noteworthy that, in the more advanced cases of our series, granulocytic hyperplasia with a preponderance of myelocytes was the outstanding feature of the bone-marrow picture,—a finding at variance with the observations of Sabin and her collaborators, who state that the fact that the bone marrow as a hemopoietic organ is less sensitive than the lymph nodes is shown not only by the lack of change in the granulocytes but also by the slight changes in the red cells.

The effects of radium on the lymphoid tissue in our experiments may well be divided into the three stages designated by Sabin and her co-workers as "first, a period of stimulation to the stem cells; second, a shift to the immature stage known as the lymphoblast; and third, a depletion of the nodes due to such a damage to the stem cell that the losses in lymphocytes can no longer be made up".



Exhibit 40.—Experimental Radium Poisoning.

Subsequent studies on these animals also revealed that the radium is stored not only in the alveolar bone of the jaw, but also in the teeth themselves, producing a pronounced alteration of the entire morphologic picture of the tooth.

There is a marked disturbance in calcification, with resorption of teeth and the formation of ankylosis by the ingrowth of newly formed bone, which also replaces the absorbed bone of the alveolar process. The essential changes in the enamel organ consist of flattening and atrophy of the ameloblasts, with hyperplasia of the stratum intermedium, and subsequent degeneration and necrosis of the entire formative structure. The normal pulp tissue is replaced by abnormal, irregular secondary dentine masses. The surrounding periodontium shows an extreme hyperplasia of fibroblastic tissue, with invasion of surrounding structures. The development of cysts arising from epithelial rests in this membrane is also an interesting finding.

OPINIONS AND PLANS

ABSTRACTS FROM OTHER MEDICAL JOURNALS

IMMUNIZATION AGAINST POLIOMYELITIS

The illustrations accompanying this article are reproduced from the A. M. A. Journal of June 26, 1937.

Physicians have been impelled to seek information regarding means for preventing poliomyelitis by outbreaks of the disease in Alabama and Chicago and by popular articles on nasal sprays, particularly that by Paul de Krief in the Ladies' Home Journal of March, 1937. During the past year the Journal of the American Medical Association has published three articles summarizing our latest knowledge of the means of blocking the route of entrance of the disease into the body.

THE FIRST A. M. A. ARTICLE

The first article is in the Journal of December 26, 1936, page 2102, by E. W. Schultz, M.D., of Stanford University, California, whose paper is entitled "Immunity and Prophylaxis in Poliomyelitis". Dr. Schultz shows that man is the only animal that is susceptible to natural infection with poliomyelitis; and that the virus enters the body through the axis cylinders of the olfactory nerves, which lie almost bare on the surface of the mucous membrane in the peak of the vault of the nasal cavity. Complete sectioning of the olfactory nerves after the virus has been instilled into the nose prevents the development of the disease.

A monkey that has the disease never gives it to other monkeys that are closely associated with it in the same cage.

Immunity is not produced by antibodies in the serum; for virus mixed with the serum of recovered animals remains potent. Even if the blood serum of the infected person were potent, it would not reach the bare olfactory nerves on the surface of the mucous membrane.

The only hopeful method of artificial protection against poliomyelitis virus is that of rendering the nerve endings impervious to the passage of the virus. Sprays of a weak solution of aluminum sulphate, tannic acid, picric acid, or many other chemicals have been found efficient; but experience has shown that a one per cent solution of zinc sulphate is the most efficient and the least irritating to the nose.

THE SECOND A. M. A. ARTICLE

The second article is contained in the Journal of the American Medical Association of June 26, 1937, and is by E. W. Schultz, M.D., and his assistant, L. P. Gebhardt, M.A., on the subject "Zinc Sulphate Prophylaxis in Poliomyelitis". The article reviews the mode of entrance of the virus, and the choice of zinc sulphate for protection, and of pontocaine as a local anesthetic, for every efficient solution is somewhat irritating when it is applied to the upper part of the nasal cavity.

The solution which was finally chosen for prevention consists of:

Zinc sulphate	1.	per cent
Pontocaine	1.	per cent
Sodium chloride	0.5	per cent

THE THIRD A. M. A. ARTICLE

The third A. M. A. article is by Drs. Peet, Echols, and Richter, of Ann Arbor, Michigan, and follows immediately after the second in the Journal of June 26, 1937. It deals with the technic of applying the zinc sulphate solution that is described in the second article. The anesthetic in the spray causes a temporary impairment of the sense of smell, but the sense returns in about a week.

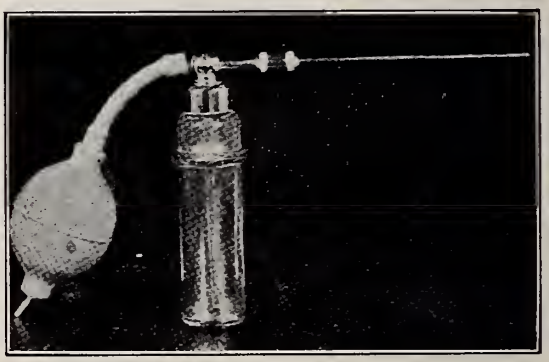


Fig. 1.—Atomizer with long, narrow tip.

The solution must be applied to the extreme upper part of the nasal cavity in order to reach the olfactory nerve. In a monkey, the solution will flow upon the nerve readily if the spray is dropped or sprayed into the nose when the head is simply tilted back; but in a child this procedure is extremely uncertain. The authors therefore developed the method of making the applications under direct vision, using an atom-

izer with a long, narrow metal tip, that is passed to the extreme upper part of the nasal cavity. The authors recommend the following method of its use:



Fig. 2.—Position of the child, the nurse, and the operator.

The subject is seated and an attendant holds the head tilted backward about forty-five degrees. This is the usual position for a nasal examination. A speculum is introduced into the naris and under direct vision the spray tip is inserted upward along the septum until definitely past the middle turbinate. If it impinges on the roof of the nose, it is slightly withdrawn. The bulb is squeezed the number of times required to introduce one cc. of solution. This amount, according to our x-ray and necropsy evidence, completely covers the olfactory area. A similar procedure is then carried out on the opposite side of the nose. Loss of the olfactory sense is thus obtained.

If a child is too young to be coöperative, the authors recommend that he be laid on his back with his head hanging down over the edge of the table (the Proetz position), and the solution dropped into the nose by use of a medicine dropper. If this method is used, pontocaine should be omitted, since the anesthesia may inhibit the protective cough, and permit some of the solution to enter the lungs, with the subsequent danger of pneumonia.

The authors conclude with the following paragraph:

The use of an atomizer with the ordinary tip introduced into the naris is of no value, since in the majority of cases the spray does not pass upward beyond the middle turbinate. A special spray tip must be introduced to the region of the cribriform plate under direct vision. At least one cc. of solution should be sprayed over each olfactory area. This procedure can be carried out effectively only by one trained in its technic.

THE ALABAMA DEMONSTRATION

The authors of the A. M. A. articles refer to a large-scale demonstration in spraying a picric-alum solution into the noses of children during a poliomyelitis epidemic in Northern Alabama. During the five months,—June 1 to November 1, 1936,—there were 360 cases reported, with 30 deaths. The demonstration by spraying is described in the American Journal of Public Health of February, 1937, page 103. The Alabama State Department of Health supplied the material, and an officer from the U. S. Public Health Service met groups of physicians and demonstrated the use of the

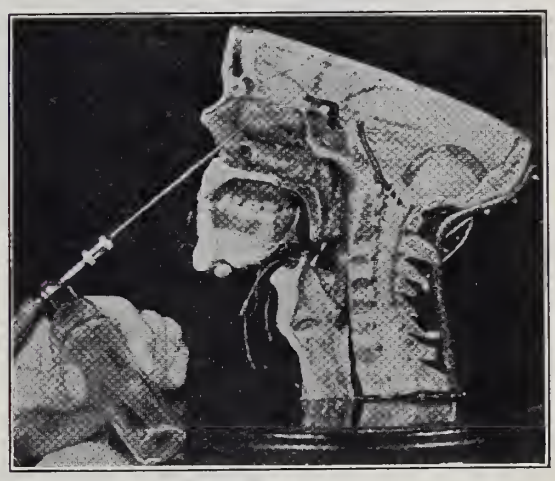


Fig. 3.—The needle introduced in a mannikin.

solution by the method of spraying the children's noses with an ordinary atomizer in which the tip was inserted only into the outer part of the nostril. It had been intended that the physicians themselves should do the spraying, but the simplicity of the method and the willingness of the parents to do the spraying had the result that most of the spraying was done by parents.

A survey showed about 8000 children received the spraying with some degree of regularity. No serious results of a bad nature were found.

The results in preventing poliomyelitis showed a very slight reduction in the incidence of poliomyelitis among the sprayed children over those not sprayed, the actual figures being as 18 is to 21.7—a proportion that might exist in any two groups that may have been chosen.

SURVEY OF CHRONIC DISEASES

The charts accompanying this article are reproduced from the A. M. A. Journal of May 29, 1937, by permission.

Chronic diseases have cumulative effects on civic life because of their increasing rate of development as the average age of the population increases; but public provision for their care is limited chiefly to the crippled, the tuberculous, the syphilitic, and the mentally diseased.

and that family doctors might be asked to confirm the diagnoses; but no information of progress would be given out until the project was completed, and the results published by the U. S. P. H. S.

A brief reference to the progress of the sur-

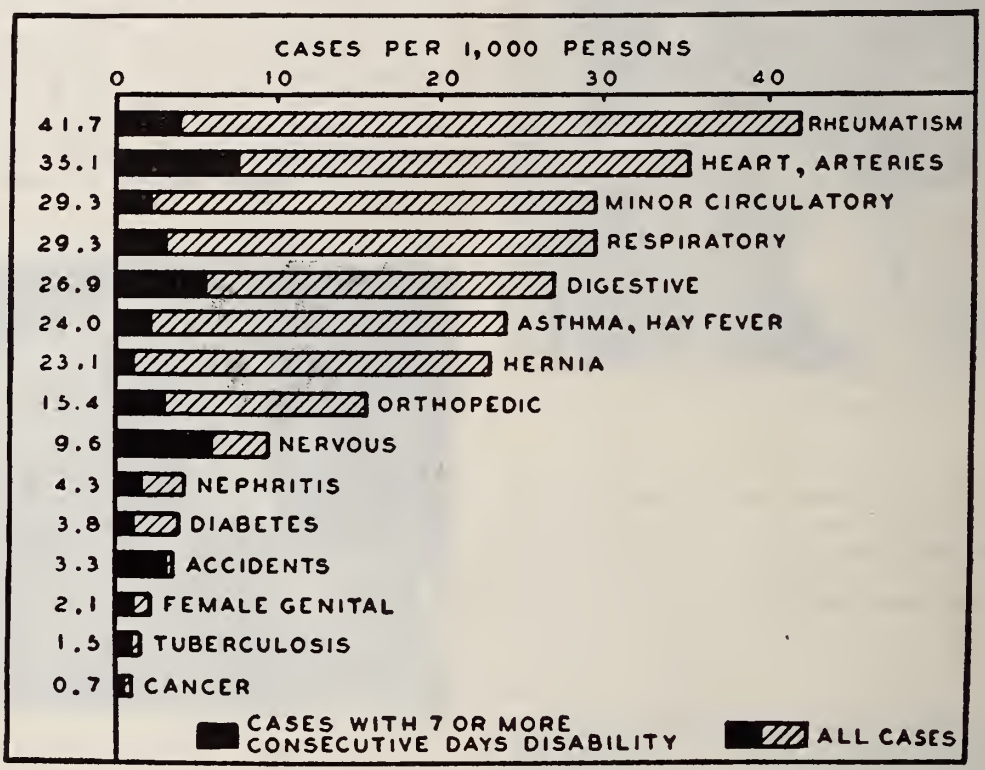


Chart 1.—Prevalence of certain chronic diseases and gross impairments.

The proposed survey of chronic diseases by the United States Public Health Service was described in the Journal of the A. M. A. of October 5, 1935, pages 1121, and 1127. The study embraced ninety-five cities in nineteen States, the New Jersey cites among them being Bridgeton, Lambertville, Newark, Somerville, and Trenton. About 5000 W. P. A. workers were assigned to the project, and 750,000 families with 3,000,000 population were on the list for investigation.

The plan was discussed in the Welfare Committee of The Medical Society of New Jersey on January 19, 1936 (Journal, Feb., 1936, pp. 97 and 108). The representative of the U. S. P. H. S. stated that the actual work of the survey would be done by W. P. A. workers,

vey is contained in the Journal of the A. M. A., February 27, 1937, p. 66B. An installment of the report was printed in the Journal of the A. M. A. of May 29, 1937, p. 1876, as an eleven-page article by George St. J. Perrott and Dorothy F. Holland, statisticians of the Service. The article in May described the results of the survey in an unnamed "Stable industrial community of some 150,000 persons", made between November, 1935, and February, 1936, when a cross-section of about 18,000 persons was canvassed.

Among the surveyed population, 22 per cent were reported as having "A chronic disease, orthopedic impairment, or serious defect of vision or hearing, which had existed for at least three months".

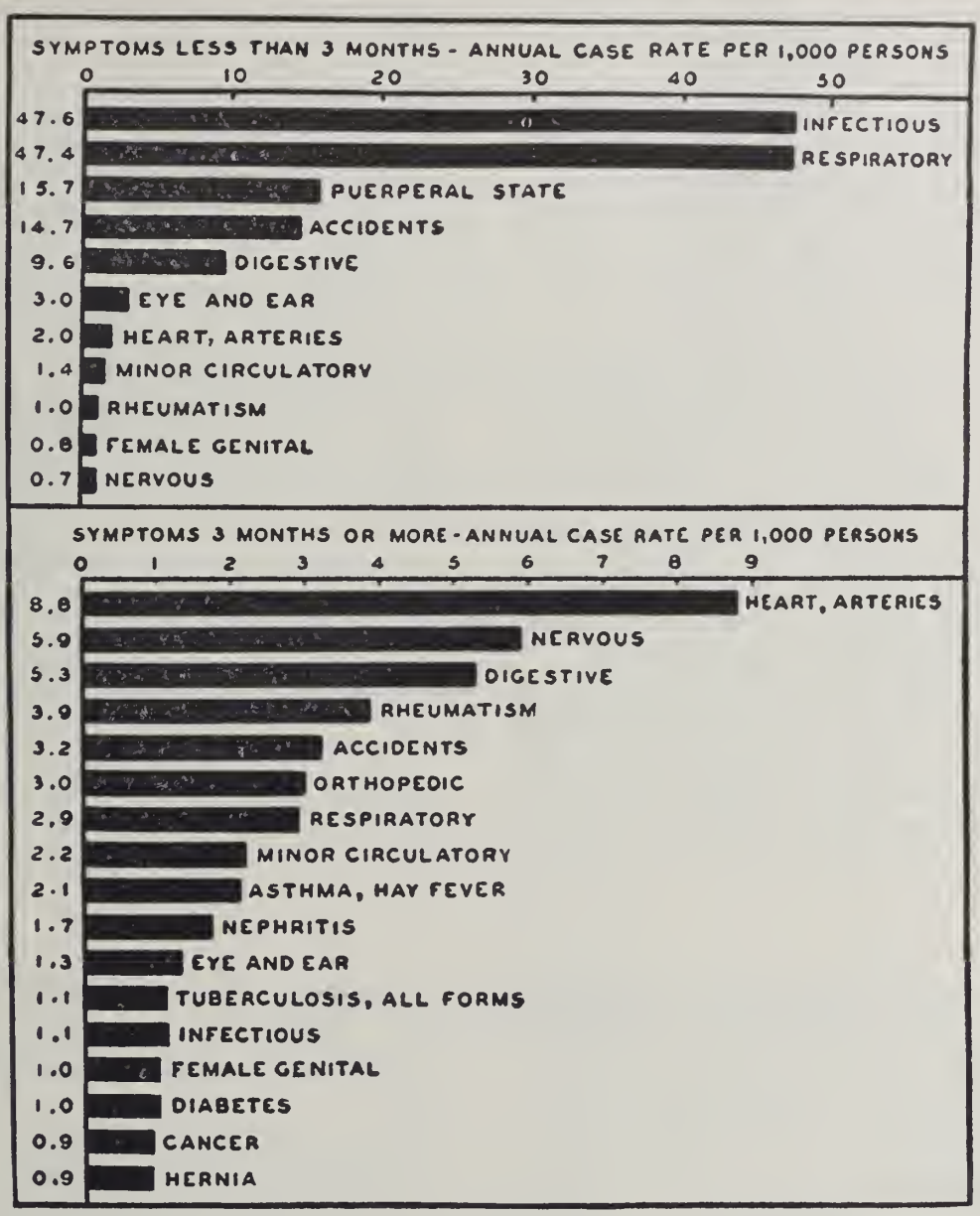


Chart 2.—Incidence of disabling illness by cause.

During the year about four per cent of the surveyed population had been disabled for one week or longer, and one per cent continuously so, as the result of chronic impairments due to disease or injury.

During the year of the study, the 18,000 who had been surveyed showed 778 cases of disablement of at least seven days; and of these 581 were bed cases. The class of disabilities from which they suffered were as follows:

Cardio-vascular-renal	146
Cancer	14
Diabetes	16
Orthopedic from accidents	90
Nervous diseases	93
Digestive diseases	82
Hernia	14
Rheumatism	59
Respiratory diseases	70
Tuberculosis (all forms)	19
Minor circulatory diseases	32
All other causes	143
	778

The total case rate of impairments reported on the day of the canvass was 279 per thousand persons. A footnote reads:

> The combined surveys of 1929-1931 in Massachusetts indicated that 29 per cent of persons aged forty and over were sick with chronic disease. In the present survey, gross impairments as well as chronic diseases were recorded, resulting in a higher crude prevalence rate; thus, 42 per cent of persons aged forty-five and over were reported to have a chronic disease or gross impairment.

SOME OF THE CONCLUSIONS

1. About one in every five persons canvassed was reported to have a chronic disease or defect on the day of the invesitgator's visit; and one in twenty-five was reported to have been disabled for seven or more days during the year by a chronic condition.

One in ten of the unemployed males between the ages of twenty-five and sixty-five had been disabled by chronic illness for a week or more during the year of the survey; while among the employed the rate was one in fifty.

2. The burden of chronic disease in lost time and cost of medical and nursing care is indicated by the fact that while only one-fourth of the disabling illnesses, and somewhat over one-third of the hospitalized cases were chronic, these cases accounted for over two-thirds of the total annual days of disability recorded for the surveyed population and for four-fifths of the annual hospital days. Chronic cases likewise absorbed one-half of the calls of physicians, and almost three-fourths of the bedside nursing days, although acute illnesses predominated among cases attended.

3. The favorable effect of the local system of emergency medical relief was apparent in the relatively large volume of physicians' services received by the average person in the relief population. However, the higher incidence of chronic illness in the relief group resulted in less care by a physician for the average chronic case than was given in the average case in the non-relief population.

There is very little said about the results of treatment of the chronic cases. The following paragraph (p. 1885) suggests that greater provision for home care would be desirable.

> The large volume of hospital care absorbed by chronic cases, particularly among the low-income groups, suggests the need for such centralized supervision, to the end that hospital care may be restricted to cases requiring institutionalization; while in other appropriate cases, care in the home may achieve more effective results from the standpoint of treatment and its cost to the community.

The report on the five municipalities surveyed in New Jersey will be awaited with interest.

ITEMS FROM THE MICHIGAN STATE JOURNAL OF MEDICINE

Recent issues of The Journal of the Michigan State Medical Society contain several articles of interest to practicing physicians of New Jersey.

1. BROADENING THE SCOPE OF MEDICAL SERVICES

Page 583 of the August Journal of Michigan contains the following editorial on the increasing scope of the public health activities of the Society:

The influence, prestige, and scope of activities of the Michigan State Medical Society continue to increase. More and more it is becoming the center of State-wide medical activity in education and service. The advice of the State Society is being sought in many quarters where medical service plays a part. As a quasi-public institution, the Michigan State Medical Society gladly accepts these added responsibilities, and gives generously of its technical knowledge to those who seek it.

The following editorial from the *Detroit Free Press* of June 25, 1937, illustrates a recent case in point:

> The joint effort to improve medical service in the Michigan prisons and among paroled persons agreed upon by the Michigan State Medical Society, the State Prison Commission, and the Parole Commissioner, appears to be a practical and valuable departure.
>
> As Commissioner Gellein explains it, the medical society agrees to provide internes at the prisons, and to furnish medical care for parolees in sparsely settled communities where their examination and treatment is now something of a problem.
>
> Under this arrangement young physicians will get valuable practical experience, particularly in dealing with social diseases, and the prison physicians will get aides who are eager to increase their knowledge and skill and can be counted upon to give the best service that is in them.
>
> The benefits to prisoners are of course evident.
>
> Commissioner Gellein considers the departure the most advanced move in penology the State has

taken, and there seems to be no reason to dispute his estimate.

2. THE COST OF PRACTICING MEDICINE

Page 580 of the August Journal prints two tables showing the results of a careful study of the average gross and net incomes of fifty physicians who had kept an accurate record of their incomes and expenses. Each table shows the expenses to be charged against each dollar of the doctors' gross incomes.

	Population		
	Less than 8,000	8,000 to 99,000	Over 99,000
Gross Cash Income	$1.00	$1.00	$1.00
Cash Expenditures:			
Rent	.04	.07	.09
Drugs	.12	.06	.08
Salaries	.05	.11	.10
Automobile	.04	.04	.04
Miscellaneous	.06	.08	.06
Total	$ .31	$ .36	$ .37
Net Cash Income	$ .69	$ .64	$ .63

TABLE 1

Incomes and expenses of fifty physicians grouped according to the population of the community in which they practice.

	Less than $6.000 per Year	$6,000 to $12,000	Over $12,000
Gross Cash Income	$1.00	$1.00	$1.00
Cash Expenditures:			
Rent	.08	.07	.07
Drugs	.12	.07	.07
Salaries	.07	.09	.12
Automobile	.06	.05	.04
Miscellaneous	.08	.06	.08
Total	$ .41	$ .34	$ .38
Net Cash Income	$ .59	$ .66	$ .62

TABLE 2

Incomes and expenses of the same fifty doctors as in Table 1, grouped acording to their gross incomes.

Table one divides the doctors into three groups according to populations of their communities into less than 8,000; 8,000 to 99,000, and over 99,000. The net cash income in the three groups is $.69, $.64, and $.63, respectively—not a great difference.

Table two divides the physicians into three clases according to their gross incomes,—less than $6,000; $6,000 to $12,000; and over $12,000. The net cash income from each dollar received is $.59, $.66, and $.62,—here again not a great difference.

It will be profitable for every doctor to make similar estimate of his own gross and net income, and compare it with the figures given in the tables.

3. ANTE-NUPTIAL PHYSICAL EXAMINATION

The August Journal, page 584, says that the 1937 law of the State of Michigan provides that before a marriage license is issued, the man and the woman shall each present to the county clerk a certificate of a physician stating that he has examined the person and found him or her to be free from a venereal disease. When it is indicated, a Kahn test for syphilis or a microscopic test for gonococci shall be made. The State Department is authorized to examine a specimen submitted by a physician, free of charge. Misrepresentation or disclosure of the result of a test to anyone except a county clerk shall be a misdemeanor.

4. MEDICAL POLITICIANS

The June issue of the Michigan Journal contains the following editorial on "The Phsician,—Scientist and Economist":

Should the modern physician be concerned only with scientific medicine? or should he be actively engaged also in the politics and economics of medicine? Is it possible for a physician to be active in the business of organized medicine and still be a scientific practitioner? These are questions which we hear raised frequently.

In the minds of some of our colleagues the idea exists that our so-called "medical politicians" are not scientific physicians. These distorted views have apparently arisen from the failure of their possessors to have analyzed the personnel of the men active in medical politics and economics.

The practice of medicine today must be twofold,—scientific, and economic. If all physicians devoted their energies only to the science of medicine, and continued to delegate the "business" of organized medicine to laymen, the need for the science of medicine would soon disappear. Complete socialization would be inevitable, and with it the deteriorating effect upon its scientific development.

Since the questions have arisen, it is interesting to analyze our State Society as to its committee and official personnel. Whose names appear among our "Medical politicians"? Are they inferior practitioners? Are they men of inferior scientific achievement? It is not necessary to list these leaders in our medical organization. They are often men of national reputation, practitioners and specialists to whom the scientific medical world points with pride.

Our advice to the 4,000 physicians of the Michigan State Medical Society is to emulate your "Medical politicians"—both in their scientific achievements, and their contributions to your medical organization in its political and economic aspects.

Your energies should be devoted to both phases of modern medicine if it is to progress.

5. THE BASIC SCIENCE LAW

The Michigan State Journal of Medicine of July, 1937, page 495, prints the photographs of the nine members of the Legislative Committee of the Society with the caption:

At great personal sacrifice, these physicians gave generously of their time and talents during five long months to engineer through the 1937 Michigan Legislature the most important preventive medical measure presented to the Legislature during the past thirty-eight years—the Basic Science Law.

Each and every physician—and all the people—owe a debt of everlasting gratitude to the chairman and members of the Legislative Committee of the Michigan State Medical Society.

The June issue, page 399, contains the following list of States having Basic Science Laws, and the years of their enactment:

Arizona, 1933
Arkansas, 1929
Connecticut, 1925
Nebraska, 1927
Oregon, 1933
Washington, 1927
Wisconsin, 1925

The July issue, page 489, copies the following comment on the Basic Science Law from the Journal of the Kansas Medical Society, May, 1937, page 216.

As amended, the law exempts osteopaths, chiropractors, and all other practitioners who are now regulated by their State Board Examiners.

Several other branches of the healing arts do not have state board examiners; therefore their representatives who meet the requirements of this law may gracefully present themselves to the public with their qualifications.

ANNUAL MEETINGS, NEW JERSEY, WISCONSIN, AND INDIANA

The September issues of the Journals of Wisconsin and Indiana contain the announcements of the annual meetings of their State Medical Societies. It is interesting to compare these two meetings with that of The Medical Society of New Jersey, for the three societies are similar in their number of members, in the scope of their activities and their methods, and in each having a full-time executive officer and office staffs. A comparison of the prominent features of the three societies is shown in the accompanying table.

The Programs of the three meetings consist of the same standard events of the House of Delegates, scientific exhibits, and Woman's Auxiliary, and social events. But Wisconsin has the added feature of a Popular Medical Exhibit, called "The Hall of Health".

	New Jersey	*Wisconsin*	*Indiana*
Date in 1937	Apr. 27-29	Sept. 14-17	Oct. 4-6
Number of Members	3621	2150	2918
Attendance	694 (1164 at A. M. A. meeting)	1200 (Estimated)	1300 (Average 1934-36)
Scientific Papers	42	98	31
Scientific Exhibits	52	19, and a popular health exhibit	10; and 30 movies
Technical Exhibits	35	33	20
Pages of Annual Reports	58	15 (In outline only)	30

Statistics of the Annual Meetings of Three States

THE HALL OF HEALTH

A unique feature of the program of the annual meeting of the State Medical Society of Wisconsin on September 14-17 was its extensive scientific exhibit called "The Hall of Health", for a popular audience. This feature is described in the Wisconsin Medical Journal of September, 1937, page 761, as follows:

"The Hall of Health in the Milwaukee Auditorium is one of the efforts that your Wisconsin doctors of medicine and dentistry, in cooperation with public health officials, pharmacists, and nurses, make to bridge the gap between the layman and the doctor. The Hall of Health is dedicated to the public good, in

the hope that freedom to search for the truth and to apply the gifts and knowledge of science will be conserved to benefit, in a magnified manner, the bodily and mental health of man in the future."

The Journal devotes fourteen pages to a detailed description of the forty-two exhibits, which are listed as follows:

1. History of X-Rays. The Milwaukee Roentgen Ray Society.
2. Story of Anesthesia. Columbia Hospital, Milwaukee.
3. Burns, Their Prevention and Treatment. Milwaukee Children's Hospital.
4. Tuberculosis Prevention. Wisconsin Tuberculosis Association.
5. Laboratory Diagnosis of Disease. State Department of Health.
6. Embryology. Marquette School of Medicine, Milwaukee.
7. Pattern of Blood Vessels. Marquette School of Medicine.
8. Cancer. Marquette School of Medicine.
9. Bright's Disease. Milwaukee County General Hospital.
10. The Mouth and Teeth. Marquette University Dental School.
11. Deformities and Their Prevention. State Division of Crippled Children.
12. Public Health. Milwaukee Health Department.
13. The Transparent Woman. S. H. Camp & Co.
14. Preventive Medicine. Wisconsin State Board of Health.
15. Milestones of Nursing. Wisconsin State Nursing Association.
16. Hall of Sight. Sight Saving Council of Milwaukee, Inc.
17. Hygeia. A. M. A.
18. Medical Examinations. National Board of Medical Examiners, Philadelphia, Pa.
19. Cancer and Hospital Care. American College of Surgeons, Chicago, Ill.
20. Syphilis. A. M. A.
21. Health Information. Mechanical Nostrums. Objectionable Cosmetics. Posture. Patent Medicine Testimonials. Hippocrates. The A. M. A.
22. Pharmacy. Wisconsin Pharmaceutical Association.
23. Medical Education. Association of American Medical Colleges.
24. Occupational Therapy. The Junior League Curative Workshop, Milwaukee.
25. Foods. Milwaukee Downer College.
26. The Doctor. A familiar picture in three dimensions. Petrolagar Laboratories, Chicago, Ill.
27. Mental Hygiene. The Wisconsin State Board of Control and the Wisconsin Society for Mental Hygiene.
28. Organized Medicine in Milwaukee. The Medical Society of Milwaukee County.
29. Hobbies and Health. The Woman's Auxiliary of the Milwaukee County Medical Society.
30. The Teeth and Mouth. Wisconsin State Dental Society.
31. Tooth-Ring Bacterial Analyses. University of Illinois, Chicago, Ill.
32. Story of Cancer. American Society for the Control of Cancer.

The announcement closes with the statement:

The Hall of Health represents a million-dollar exhibit. It is a remarkable achievement in the field of health education. Tell your friends—invite them to attend. No admission charge.

CAREERS IN ADMINISTRATIVE MEDICINE

The August issue of the Westchester Medical Bulletin, the organ of the Medical Society of Westchester County, New York, prints the following editorial comment on the practice of medical administration:

"Is there not now a new career open for full-time physicans as well as medically informed laymen in administrative medicine? Have we in our ranks men sufficiently informed of the present and the future needs of medicine, men sufficiently equipped by nature and training to become full-time lobbyists? There is no need to speak softly. Nor is there any reason why a medical lobby should not function honestly and openly for the interest of medicine in the political arena. The future of medicine is being argued there, now; plans for the permanent welfare organization of this State are being laid there, now; the whole structure of the public medicine of the future is being built there, now.

"In that arena, at this time every party at interest,—charitable organizations, insurance companies, employers' groups, religious bodies, foundations for this and that,—are suitably and adequately represented, professionally,—except medicine. And so we ask on behalf of the public: Whose fault is that?" (See editorial, p. 596.)

STATE SOCIETY ACTIVITIES

THE SUB-COMMITTEE ON PUBLIC HEALTH

A meeting of the Sub-Committee on Public Health of the Welfare Committee of The Medical Society of New Jersey was held in Long Branch, in the home of its Chairman, Dr. Stanley Nichols, on the afternoon of Sunday, September 26, 1937.

There were present, Dr. Herrman, President; Dr. Nichols, Chairman, and Drs. Ireland, Teimer, Levy, Knight, and Hummel, members; Drs. Orton, Moffat, Bingham, and Dewis, Chairmen of Advisory Committees; Dr. Wilkes, Executive Officer, and Dr. Frank Overton, Editor; and also Dr. Kler, Chairman of the Public Relations Committee, and Mr. Benson of the newspaper publicity staff.

Since this was the first meeting of the committee after the Annual Meeting of the State Society, Chairman Nichols referred to the great amount of work which had been done in securing the personnel of the several committees, and the outline of their activities as set forth by the several chairmen in the communication of President Herrman in the August Journal, page 520.

Dr. Nichols also referred to the fact that this year is the "Sabbatical" year—the seventh—of the Public Health Committee, as it is at present organized, and that the committee has developed its scope of organization and program through the years since 1931, up to its present efficiency under the Welfare Committee.

ORIGIN OF THE PUBLIC HEALTH COMMITTEE

As a matter of information, the following excerpts from the Transactions of the House of Delegates of 1931, page 48, are printed.—Editor's Note.

On motion of Dr. Haggerty, it was carried that "A Public Health Committee be appointed to confer with the State Board of Health and other public health authorities on the revision of health laws".

Dr. Frank C. Johnson, of New Brunswick, said: "I have a request from the Governor's Conference on Child Health and Protection, held in New Brunswick last March, for the appointment of a committee by this society, by the President, the number is not given so I would suggest five, to cooperate with the Continuation Committee of the Governor's Conference on Child Health and Protection in a review of the work of the various bureaus of the State that have to do with the health and protection of children, looking toward improvement of their service."

Dr. Warner: I move its adoption.

The motion was seconded.

Dr. Johnson: This comes out of the Governor's Conference held in New Brunswick last March, which was attended by 1600 people. It was a very important gathering and a very interesting one, upon which I shall read a report on Friday, but that will be after all business is completed. Therefore, this motion is asked for now, together with action on it. That committee might be the same committee just appointed on public health supervision, a review of public health work. I don't see any reason why they shouldn't be the same committee, as so many committees are being appointed now at the discretion of the Chair. So far as I know, it might be the same committee with the idea that the work of the Children's Bureau and other bureaus of the State that are dealing with public health matters may be improved, and this group of people of all sorts, of many organizations, asks for coöperation of the State Medical Society. Such coöperation in the past has not been adequate or extensive. This is an opportunity to work with the groups that are doing a great deal of work, as we all know, in a public health way.

President Sommer: Why not amend your motion to instruct that Pulic Health Committee to take over as one of its activities this particular thing.

Dr. Johnson: That was what I had in mind.

The motion was seconded and carried.

The Transactions of 1932, page 42, contain the following report of Past President W. G. Schauffler, of Princeton, first Chairman of the newly-formed Public Health Committee.

A communication was sent to all such Organizations and Departments and to the County Medical Societies, asking for their coöperation.

The work of the committee was divided into the following five subjects:

1. State Board of Health, particularly as to the need of full-time health officers.

2. The relationship of physicians to child health activities in the State.

3. The relationship of physicians to school health matters.

4. The relationship of physicians to hospitals and hospital clinics.

5. The relation and coördination of physicians to health and welfare organizations.

MEETING OF SEPTEMBER 26, 1937

Chairman Nichols, continuing his remarks, said:

"It took four years for the State Society to become 'Public Health-minded'; and the major work of the committee during the last two years has been to secure the coöperation of the *county societies*. The next development will be to develop the same spirit in the individual members, about 1000 of whom may be classed as assuming an active leadership in public health activities."

Dr. Nichols also commended the action of several county societies in duplication of the committees of the State Society. He then called on the Chairmen to outline the activities of the several Advisory Committees:

COMMITTEE ON VENEREAL DISEASE

Dr. C. Byron Blaisdell, of Long Branch, Monmouth County, Chairman of the Advisory Committee on Venereal Disease Control, discussed the following activities of the committees:

1. Plans for the free distribution of arsenicals for the treatment of patients of low incomes and indigents.
2. The appointment of a committee on venereal disease control in each county society.
3. Coöperation with Dr. Kler, Chairman of the Sub-Committee on Public Relations, in the assignment of members to address public meetings on the subject.
4. The revision of the chapter on Venereal Diseases of the Handbook so that it will conform to the newer plans of the State Department of Health.
5. Setting up centers for demonstrating methods of diagnosing and treating venereal diseases, as has been done in Essex County.
6. Getting out a series of printed forms setting forth the accepted standards of treatment.
7. Providing a venereal disease movie to be shown in each county society.

Dr. Blaisdell announced that Mr. William H. MacDonald had been appointed Supervisor of the activities of the State Department of Health in Venereal Disease Control, with Dr. A. J. Casselman as Advisory Consultant.

President Herrma nspoke of the principles which should be observed in a venereal disease clinic. The clinic is not designed for syphilitics who are not in a contagious stage, and can pay their own physician. Still, if a syphilitic is in a contagious condition, he is a public menace whom the State should control and treat, even f he can pay his doctor, but is unwilling to do so.

CANCER CONTROL

Dr. Henry B. Orton, Chairman of the Advisory Committee on Cancer Control, referred to the program of his committee as outlined on page 522 of the August Journal. He especially stressed the importance of stimulating physicians to be "Cancer-minded" and to investigate suspicious cases early in the course of the disease.

President Herrman spoke of the need of increased facilities for the persistent treatment of chronic cases of cancer, and mentioned the favorable attitude of Commissioner Ellis in regard to providing increased nursing and other means of treatment.

Dr. Herrman also spoke of the opportunities of the Curie Institute, especially in providing administrative facilities for investigating and following up cancer patients. He also emphasized the need of a close liaison of the Institute with practicing physicians.

CRIPPLED CHILDREN

Dr. Barclay W. Moffat, Chairman of the Advisory Committee on Crippled Children, reported that the committee was working harmoniously with the Commission on Crippled Children. Since the Commission is the disbursing agent for State funds, it must define what constitutes crippling. It also applies the standards of the American College of Surgeons in determining who should be recognized as an orthopedic surgeon. Dr. Moffat referred to the need of a field survey in order to determine the number of crippled children who need the assistance of orthopedists and neurologists. Doctors are responding in a gratifying way, and numbers of new cases are being reported.

Dr. Moffat also announced that Dr. Phelps' article on the treatment of Cerebral Palsies in the Babbitt Hospital, Vineland, had elicited favorable notices. His committee will welcome any physicians on a trip to the hospital on the afternoon of Tuesday, the 28th of September.

(A committee and guests visited the hospital on September 28, and the members expressed their deep interest in the demonstration of the cases and their management by Dr. Phelps and his assistants.—Editor's note.)

MATERNAL WELFARE

Dr. A. W. Bingham, Chairman of the Advisory Committee on Maternal Welfare, reported that arrangements had been made for the appointment of "Field Physicians" in nineteen of the twenty-one counties. Dr. Bingham described the general progress in the practice of better obstetrics, and pointed out the advantages which rural physicians will derive from

the consultant services which are offered to them. He was gratified by the response of physicians to an investigation of every maternal death, the object of the investigation being not to expose the short-comings of the doctor, but to discover means by which death may be prevented under similar conditions.

ADULT HEALTH SUPERVISION

Dr. Edwin G. Dewis, Chairman of the Advisory Committee on Adult Health Supervision, discussed the double problem of (1) developing a blank form that is suitable for practical use by family doctors; and (2) arousing physicians to use it in their practice. The obstacle at present is the feeling of the doctor that he knows his patient so well that he does not need to examine his heart and other organs. This knowledge is extremely valuable, but it must be backed up with a definite record of a condition on a particular time,—as for example, the presence of albumin in the urine on a particular day.

Dr. A. G. Ireland reported progress in developing a blank for recording the record of the examination of the school child, and said that it would probably be ready on the first of November.

PNEUMONIA CONTROL

Dr. Theodor Teimer, Newark, speaking on behalf of the Advisory Committee on Pneumonia Control, said that a mehtod of pneumonia control has been adopted by 400 members of the Essex County Medical Society, and that the plan involves three provisions:

1. For making a prompt diagnosis of the type of pneumococcus.
2. For distributing the proper serum to the doctor within a very short time after a diagnosis has been made.
3. For teaching the doctor what part he must take in diagnosis and treatment.

Much time and effort must be put forth in each of these three phases of control before the mortality from pneumonia is markedly reduced.

GETTING WORK DONE

President Herrman spoke on various aspects of the discussions, and pointed out ways of dealing with troublesome problems of administration. He complimented the chairmen for their excellent programs for the activities of the coming year. The next step will be that of getting the work done. If any chairman needs assistance, he can obtain it even to the extent of enlarging the number of members of his committee.

NEW JERSEY TUBERCULOSIS LEAGUE

The Annual Meeting of the New Jersey Tuberculosis League will be held in the Woodrow Wilson Hotel, New Brunswick, on Friday, October 22, 1937. The program committee, under the Chairmanship of Dr. J. H. Kler, of New Brunswick, Chairman of the Sub-Committee on Public Relations of the Welfare Committee of The Medical Society of New Jersey, has prepared a program for five sessions:

1. A Health Education and round-table session at 9:45 a. m., conducted by W. A. Doppler, Ph. D., of the National Tuberculosis Association.
2. A business session at 11:30.
3. A luncheon session at 12:30, with "Rehabilitation of the Tuberculosis Patient" as the central topic.
4. A School Health session at 2:15, on "Tuberculosis Case Finding".
5. An evening session at 6 p. m., consisting of a "Pep Dinner" for the promotion of the sale of Christmas Seals.
6. Dr. Kler is also planning an evening Medical Session to be held in the new Roosevelt Hospital,—The Middlesex County Sanatorium,—at Metuchen, at 8:30 p. m. This will be a clinical session consisting of a review and demonstration of the latest diagnostic and therapeutic measures in tuberculosis according to the following program:
   a. Tuberculin—its preparation and administration, and the exhibition of skin tests on patients who had been injected two or three days previously.
   b. X-ray plates,—their exposure and interpretation.
   c. The blood sedimentation test.

This session should appeal to physicians, and be the occasion for a goodly number to assemble in a social and scientific conference.

TUBERCULOSIS SURVEY OF HIGH SCHOOLS

THE BERGEN COUNTY PLAN

By George M. Levitas, M.D.
Chairman, Health Education Committee, Bergen County Tuberculosis Association
and
Joseph R. Morrow, M.D.
Medical Director, Bergen Pines Sanatorium

Bergen County is a suburb of New York City, and is connected with it by the George Washington Bridge. It has an area of 237 square miles, and a population of 364,977 (census 1930), largely in incorporated municipalities, Garfield having 29,739, and Hackensack, 24,568

The people of the county are served by 356 physicians, located in fifty-one centers. The Bergen County Medical Society is credited with 257 members, or 72 per cent of the physicians listed in the county.

Tuberculin Testing Surveys in Bergen County are coöperative ventures in which the family physician, the Bergen County Medical Society, Bergen Pines Sanatorium, the Bergen County Tuberculosis and Health Association, the School Physician, the School Administrators, and the local Boards of Education and Health participate.

The following plan for mass testing of high school students has the endorsement of the Bergen County Medical Society. Tuberculosis surveys of high schools are carried out only on request of the local Boards of Education.

In order to carry on a successful survey, it is essential that the actual clinic work be preceded by a far-reaching educational program, and be supplemented by a thorough follow-up.

Briefly, the plan is as follows: The School Physician and the Supervising Principal assume the responsibility for the survey. The Bergen Pines staff is responsible for the clinic work (giving tests, reading reactions, x-raying reactors, and reporting findings to the family physicians). The Bergen County Tuberculosis and Health Association is largely responsible for the preliminary program, underwrites the cost of materials used in the survey with Christmas Seal sale funds, and assists with the follow-ups. The Tuberculosis and Public Health Committee of the Medical Society, local Boards of Health, School Medical Departments and the Board of Education lend their assistance in each part of the survey.

PRELIMINARY WORK

A. *Meeting of those to participate* in the work: Superintendent of the Sanatorium, High School Principal, School Physician, School Nurse, Executive Secretary of the Tuberculosis and Health Association, Chairmen of the Tuberculosis and Public Health Committees of the Bergen County Medical Society and the local Boards of Health and Education. At this meeting the following points are discussed:

1. Date of the survey.
2. Room facilities, record cards, etc.
3. Financing.
4. Letters to physicians.
   a. Preliminary letter specifying the date and plan of the survey.
   b. A second letter, at the completion of the survey, to report the findings and explain the plan for follow-up.
5. Policy adopted in reporting the findings to the family and school physicians.

B. *Meeting of physicians* serving community to be surveyed. This meeting is open to all physicians. The plan is presented and discussed by the school and local physicians, members of the Tuberculosis and Public Health Committees of the Medical Society, Superintendent of the sanatorium, and others. A brief technical explanation of the significance and modality of this procedure and the results expected is made, at the same time evaluating both the tuberculin test and x-ray in the light of modern knowledge. Arrangements are made whereby either the school, the family, or the sanatorium physician will examine (and report, in writing) all severe reactors who did not come for the reading. The absolute necessity of a thorough follow-up of all positive students and their families is emphasized. The importance, in this respect, of the coöperation of the physicians and the different Tuberculosis and Nursing Associations is stressed. The surveys then will yield the beneficial results expected to follow the expenditure of so much time, effort, and money. The Executive Secretary of the Bergen County Tuberculosis and Health Association shows a sound motion picture, "Behind the Shadows", which is used in connection with all educational meetings. Literature on tuberculosis is distributed freely.

C. *Letter to Physicians.* The chairmen of the Tuberculosis and Public Health Committees of the Bergen County Medical Society send a letter to the physicians in the community advising them of the projected survey and inviting them to the special meeting above mentioned. In this letter is stated briefly the aim of the survey and the plan of procedure, and authoritative literature on tuberculin testing and its significance is enclosed.

D. *Meeting of teachers* called by the High School Principal for the purpose of enlisting the teachers' interest and coöperation, and to urge them to take the opportunity to be x-rayed. Motion picture films, slides, kits of literature and teaching units on tuberculosis are supplied to the teachers,—particularly to those in the Science Department. All other high school employees, besides the teachers, are also given a talk on the aims and value of the survey, and are strongly urged to consent to a chest x-ray examination. This meeting may be held separately.

E. *Lectures to Students.* Lectures on tuberculosis and the value of the tuberculin test are given to the students. This is done most efficiently when students are reached in small groups of not more than seventy-five, and opportunity is given for discussion. Literature is distributed. An assembly program is held at the completion of the lectures, at which time the sound film "Behind the Shadows" is shown.

F. *Meeting of Parents.* After all students have been reached and before the request slips are sent for the parents' signatures, a mass meeting to which parents are invited is held. The significance of the test is explained, followed by a discussion period. At this meeting community officials are invited to enlist their coöperation. At each one of the above meetings students, parents or guardians and all school employees are impressed with the important rôle of the family physician. They are instructed to specifically designate their doctor. Furthermore, they are informed that a complete report of the results will be mailed *to him alone.*

G. *Records.* Consent cards, students' and employees' clinic cards, etc., are mimeographed at the school. Names and addresses are typed by students in the Commercial Department.

H. *Newspaper Publicity.* Copy is prepared by the Bergen County Tuberculosis and Health Association, and is issued through the office of the Supervising Principal. Scientific facts are checked by the Sanatorium Staff.

THE CLINICAL WORK

A. *Contacts.* Before the survey, the school medical department and the Board of Health draw up a list of students known to be *contacts,* or who have definite *foci of infection* such as tuberculous bones or glands. In Bergen County the second strength PPD (purified protein derivative) is used for all Mantoux tests, except for the above mentioned students who are given first strength PPD, followed by second strength if the initial test is negative. This method has been found to be satisfactory.

B. *Tuberculin Testing and Chest X-Ray of Students.* This part of the program is carried out by the Medical Staff of Bergen Pines Sanatorium. It is requested that students remain in their home rooms rather than go to classes, and that a steady line of students, bearing their consent cards, file past the physicians for the tests. The tests are read forty-eight hours after they are given. Those students exhibiting negative reactions return to their classrooms; and those showing positive reactions form a line and are x-rayed immediately by means of the sanatorium's portable x-ray. Standard celluloid films—which cost 53 cents each—are used. Paper capes are provided for the female students. Two physicians, assisted by three nurses and two clerks, are able to test 600 students an hour, and x-ray reactors at the rate of ninety an hour, provided students come in uninterruptedly.

C. *Staff.* All school employees should be among the first to request a chest film. They are x-rayed at a suitable time.

D. *X-Ray Interpretation.* All exposed films are taken to the County Sanatorium and developed there. The Medical Staff then interprets them. The school physician and the physicians serving the community where the survey is made are invited to attend the reading of the films. All other interested physicians are welcome.

E. *Report of the Examination.* A complete report of the examination of each student is prepared at the County Sanatorium, and sent from there to the school and family physicians. Such reports contain the results of tuberculin testing, the x-ray findings, the diagnosis, and the recommendations.

F. *Financing.* In Bergen County the Tuberculosis and Health Association provides the supplies used in the survey,—tuberculin, x-ray films, capes and literature. Those students requiring x-rays are requested, if able to do so, to contribute fifty cents toward the cost of the survey. Occasionally Boards of Education, fraternal orders, or other agencies are willing to finance the project.

G. *The Medical Society.* The Medical Society of Bergen County, coöperating through its Tuberculosis and Public Health Committees,

takes active part in the preliminary and follow-up work. A complete report of the findings is printed in the Bergen County Medical Society Bulletin, and is explained and discussed at a meeting of the society by the school physician, the superintendent of the sanatorium, and the chairmen of the two committees. This offers an opportunity to emphasize again the necessity and importance of the follow-up work to the physicians serving the community in which the survey was made. The Tuberculosis and Public Health Committees and the Sanatorium Staff, in coöperation with the Executive Secretary of the Bergen County Tuberculosis and Health Association, then prepare a copy of the results and complete statistics of the survey.

FOLLOW-UP

Reports of tests and x-rays are sent to the student's family physician. On its receipt the family physician arranges for the follow-up, as outlined below.

1. Clinical observation and care of active cases.
2. Continued observation and reëxamination of cases who have suspicious chest x-ray findings.
3. Continued attention to healed and fibrotic cases.
4. Subsequent attention to cases showing x-ray evidence of primary or healed primary infection.
5. Reëxamination of positive reactors, and attempts to discover possible sources of infection in this group.
6. Subsequent re-testing of the negative reactors and chest x-raying of those that are found to be positive.
7. Examination of the families of all positive cases in an attempt to find the original source of infection.

Public Health nurses doing follow-up work in Bergen County are invaluable to the physicians in helping arrange for the desired x-rays and examinations. The follow-up is carried out under the direction and supervision of the family doctors.

RESULTS

Successful surveys result in:

A. A better understanding of the problem of tuberculosis on the part of the public.

B. Students who show evidence of the disease may be isolated and treated by their own physician, or hospitalized.

C. Through the follow-up, unrecognized cases of the disease may be discovered. Contacts may then be protected from further infection, and tuberculous patients may secure treatment.

D. Students who are in danger of developing adult tuberculosis are singled out and protected.

E. Physicians, nurses, health departments, school officials, sanatorium staffs, and health agencies official and private, work together for a common goal.

The following is a complete, up-to-date, report of all the surveys which have been made in Bergen County High Schools:

REPORTS ON STUDENTS

	Number	Per Cent
Number enrolled	5772	
Number Tuberculin Tested	3956	68.63
Number showing Positive Tuberculin Test	1706	43.12
Number chest x-rayed—Positive Reactors	1706	100.00
Negative for Pulmonary Tuberculosis	1462	85.69
Childhood Type of Pulmonary Tuberculosis	148	8.67
Suggestion of Fibrotic or Partially Calcified Foci	69	4.04
Adult Pulmonary Tuberculosis	9	0.52
Non-Pulmonary Tuberculosis	2	0.12
Non-Tuberculous Pathology	7	0.41
Definite foci of Childhood Pulmonary Tuberculosis and suggestion of Minimal Adult Pulmonary Tuberculosis	2	0.12
Undiagnosed	7	0.41

REPORT ON SCHOOL TEACHERS AND OTHER EMPLOYEES

Number x-rayed	411	
Negative for Pulmonary Tuberculosis	383	93.18
Adult Pulmonary Tuberculosis	11	2.67
Apical Fibrosis clinically insignificant	10	2.40
Cardio-vascular Pathology	4	0.97
Non-Tuberculous	2	0.48
Undiagnosed	1	0.24

SUMMARY

1. Those in charge of the surveys are highly gratified with the splendid assistance and coöperation given these projects by the medical profession, the public, the school and health officials, and the public and private agencies. It is interesting to note that 68.63 per cent of all students enrolled in the high schools studied were tested. In one school, 87 per cent of the students were tested.

2. The incidence of *tuberculous infection* among high school students in Bergen County is relatively high (43.12 per cent).

3. The incidence of *adult pulmonary tuberculosis* among high school students in Bergen County is relatively low (0.52 per cent).

4. The incidence of adult pulmonary tuberculosis among employees in high schools in Bergen County is relatively high (2.67 per cent).

CRUISE OF THE PAN AMERICAN MEDICAL ASSOCIATION

Physicians who wish to make a sea voyage this winter will do well to consider the West India trip that is planned by the Pan American Medical Association. This is the seventh annual cruise of the Association. The program includes medical meetings and exhibits on board the ship, with addresses by well-known clinicians and teachers, including Dr. James Ewing, Dr. Chevalier Jackson, and Dr. Foster Kennedy. Shore meetings will be held in several hospitals of the West Indies.

The trip will require fifteen days,—leaving New York on Saturday, January 15, 1938, and arriving back on Monday, January 31, after visits to Havana, Port Au Prince, Trujilio, and San Juan.

The listed cost ranges from $185 for an inside room up to $700 for a suite de luxe. The ship will serve as hotel at all points of call.

Information may be obtained from Dr. J. J. Eller, Director General, 745 Fifth Avenue, New York City. Dr. Eller is on the consulting staffs of the Monmouth Memorial Hospital at Long Branch, and the Fitkin Memorial Hospital at Neptune.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS SINCE JULY 1, 1937

DIPHTHERIA TOXOID

County	To July 31	Month of August	Total to Aug. 31	Average per Month
Atlantic	1	2	3	1.5
Bergen	101	39	140	70.
Burlington	9	22	31	15.5
Camden	40	26	66	33.
Cape May	2	1	3	1.5
Cumberland	13	13	26	13.
Essex	334	308	642	321.
Gloucester	67	26	93	46.5
Hudson	4	33	37	18.5
Hunterdon	0	0	0	0.
Mercer	5	7	12	6.
Middlesex	51	46	97	48.5
Monmouth	244	11	255	127.5
Morris	66	8	74	37.
Ocean	21	0	21	10.5
Passaic	312	141	453	226.5
Salem	8	12	20	10.
Somerset	234	5	239	118.5
Sussex	0	1	1	.5
Union	108	54	162	81.
Warren	36	4	40	20.
Totals	1656	759	2415	1207.5

SMALLPOX VACCINE

County	To July 31	Month of August	Total to Aug. 31	Average per Month
Atlantic	1	14	15	7.5
Bergen	348	81	429	214.5
Burlington	9	75	84	42.
Camden	26	75	101	50.5
Cape May	4	0	4	2.
Cumberland	37	86	123	61.5
Essex	426	316	742	371.
Gloucester	89	77	166	83.
Hudson	3	16	19	9.5
Hunterdon	3	6	9	4.5
Mercer	1	13	14	7.
Middlesex	38	86	124	62.
Monmouth	318	72	390	195.
Morris	16	18	34	17.
Ocean	0	0	0	0.
Passaic	234	246	480	240.
Salem	14	71	85	42.5
Somerset	229	7	236	118.
Sussex	0	0	0	0.
Union	193	262	455	227.5
Warren	57	27	84	42.
Totals	2046	1548	3594	1797.

LIST OF PHYSICIANS DYING IN NEW JERSEY IN AUGUST

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Anthony M. Bacevicz	66	Aug. 10	Elizabeth	Same	Tumor of pancreas.
Wilson A. Bailey	71	Aug. 2	Camden	Same	Arterio sclerosis.
Benjamin F. Buzby	81	Aug. 5	Swedesboro	Same	Myocardial infarct.
Morris W. Clouse	60	Aug. 27	Kearny	Same	Carcinoma of neck.
William E. Derry	81	Aug. 4	Dover	Same	Cerebral hemorrhage.
Edwin H. Harvey	67	Feb. 22	Philadelphia, Pa.	Atlantic City	Cerebral thrombosis.
Louis A. Martucci	44	Aug. 13	Newark	Newark	Acute appendicitis.
Leonidas L. Mial	75	Aug. 20	Morristown	Same	Cerebral hemorrhage.
Rodman E. Sheen	47	July 12	Somers Point	Same	Pituitary tumor.

CONTACTS AND COMMENTS

COMING EVENTS

Preparations are being perfected for the "Cancer Week" of the Passaic County Medical Society to be held October 11-13. Physicians from other counties are invited to attend the various events, which are outline on page ....

Attention is called to the account of the "Cancer Night" of the Bergen County Medical Society held in the Memorial Hospital of New York on the evening of December 8, 1936. The hospital was readily accessible to the Bergen County physicians by way of the Washington Bridge, the members being transported in buses. The papers of the evening are printed in this Journal beginning on page 597.

A feature of the annual meeting of the New Jersey Tuberculosis League to be held in New Brunswick on October 22 will be a demonstration of the means of laboratory diagnosis of tuberculosis as announced on page 636. This will be of special interest to all practicing physicians, and it is hoped that many will attend it.

Another medical society event which will appeal to New Jersey physicians is the Graduate Fortnight of the New York Academy of Medicine, November 1-12, 1937, as announced in the September Journal, page 586.

Plans are already under way for the next Annual Meeting of *The Medical Society of New Jersey,* which will be held in Atlantic City, probably in May. Some possible ideas for the program may be gleaned from the descriptions of the annual meetings of Michigan and Wisconsine, whose descriptions are printed on page 630 of this Journal.

The comparison of recent meetings of these states with those of New Jersey will be of interest to the members of the New Jersey Society. (See p. 632.)

A stated meeting of the Academy of Medicine of Northern New Jersey will be held on Thursday, October 21, 1937, at 8:45 p. m., in coöperation with the Committee on Public Health and Medical Education and the Health Committee of the Contemporary Club of Newark. The paper of the evening will be on the subject, "Personality Types and the Need for the Study of the Individual Personality Make-up in Relation to Mental Hygiene" by Clements C. Fry, M.D., of the Division of Psychiatry and Mental Hygiene, Yale University. Visiting physicians will be cordially welcomed.

The Annual Conference of the Secretaries and Editors of the several State Medical Societies will be held under the auspices of the A. M. A. in the Association's building, Chicago, Illinois, on November 19 and 20, 1937. These conferences are of great practical value both in informing the participants of the work of the A. M. A., and also in enabling them to become acquainted withe one another and with the leaders in the A. M. A. New Jersey will be well represented at the Conference. The expenses of the participants are borne by the A. M. A.

It may be that some physicians of New Jersey will wish to take the Pan American two weeks' boat trip to the West Indies, as announced on page 640.

We have run across several suggestions for literature suitable for the table in the waiting room of the doctor's office. The best and most original suggestion has come from Past President Snedecor, who keeps his table supplied with the latest issues of the popular magazines. His wife is not altogether pleased with this arrangement, for she too would like to see the latest issues once in a while. But she is patient because of its wholesome effect on the doctor's waiting patients, who sometimes wish the doctor would delay receiving them until they can finish a magazine that particularly interests them.

We might suggest that the list of periodicals on the doctor's table include the latest issue of *The Journal of The Medical Society of New Jersey.*

IF THE FAMILY DOCTOR WERE CHOSEN AS WE CHOOSE OUR PUBLIC OFFICIALS!



From the Detroit News of April 3, 1937, through the Journal of the Michigan Medical Society of June, 1937.

The Chinese have a proverb—"A picture is worth a thousand words." An item of knowledge that seems commonplace in words comes to life in a cartoon. The field of medical cartooning is almost unoccupied, but it is worthy of cultivation.

The assistance of local physicians at the disaster to the airship Hindenburg has elicited the following letter of appreciation to President Herrman from F. W. von Meister, Vice-President of the German Transport Company, 90 Broad Street, New York, on August 30:

This letter is written to you to express our appreciation for the spontaneous and efficient action taken by the members of your Association in answering the emergency call occasioned by the loss of the Airship *Hindenburg* at Lakehurst, May 6th.

This appreciation would have been expressed to you long before this, but many pressing matters, paramount among which was the care for the injured and the settlement of many other questions, prevented our writing you before this date.

This Company, as well as the German Zeppelin Transport Company, operators of the *A. S. Hindenburg,* ask you to kindly convey to those members of your Society, who actually participated in the rescue work, as well as to those who responded to the call for assistance, but were not admitted to the U. S. Naval Air Station at Lakehurst, because adequate medical assistance had already reached the Station, our deep-felt and sincere gratitude for their willingness to help.

This experience was the occasion of a valuable paper on the modern treatment of burns printed in the September issue of the Journal, page 545.

We have received a reprint of an article by Dr. J. J. Golub, Director, Hospital for Joint Diseases, New York City, entitled "Hospitiology", which is a plea for a proper word to describe the specialty which concerns all phases of hospital construction and management. The author describes the consideration of a dozen terms to designate the specialty. He finally narrowed the choice to two,—Hospitalogy, and Hospitiology,—and decided on the latter word because of its euphony. On that ground, the word Hospitalogy is by far the better term, besides embodying a term which is already familiar.

Surveys of tuberculosis among high school students of New Jersey are being promoted in several counties. An excellent survey is that of Bergen County printed on page 637 of this issue of the Journal. Any considerable reduction in the incidence of tuberculosis will depend upon the recognition of incipient cases of the disease by laboratory means, particularly the tuberculin test and the x-ray examination. After the disease is recognized, the treatment will be the problem for family physicians in their private practice.

President Herrman's son has returned home and is happily convalescing from his operation for a gangrenous appendix.

Dr. Thomas K. Lewis presided at a meeting of the Board of Trustees on October second, after recovery from his illness.

The latest reports concerning Dr. Elias J. Marsh, Treasurer of The Medical Society of New Jersey, are that he is well on the road to health after his recent operation.

On the afternoon of Sunday, October 3, a delegation of officers of the Society attended the funeral of Trustee Dr. Blase Cole, of Newton, Sussex County, who died on Thursday, September 30, as the result of an automobile accident. An account of his useful life will appear in the November Journal.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING METINGS

October, 1937

5	Camden	14	Essex
5	Cape May	14	Passaic
5	Hudson	14	Somerset
8	Atlantic	19	Warren
8	Salem	20	Middlesex
12	Bergen	21	Gloucester (Social Session)
12	Cumberland	21	Morris
13	Mercer	26	Hunterdon
13	Ocean	27	Monmouth
13	Union		
14	Burlington		

November, 1937

2	Camden	11	Passaic
2	Hudson	12	Atlantic
9	Bergen	17	Middlesex
10	Mercer (Banquet)	18	Gloucester
10	Ocean	18	Morris
11	Burlington	24	Monmouth
11	Essex		Sussex (at call of President)

BURLINGTON COUNTY

Parry M. Scott, M.D., Reporter

The September meeting of the *Burlington County Medical Society* was held on Thursday, September 9th, 1937, at Moorestown Field Club, Moorestown, N. J.

NURSING SERVICE

Dr. R. D. Anderson reported that the Board of Freeholders of the county had sent a copy of the P. W. A. project for providing free nursing to indigents, and asked for our recommendations and approval.

It was recommended that three doctors from the medical society be appointed to work with the Board of Freeholders; that the nurses selected be approved by a committee; and that monthly reports of their work be sent to the committee. It was recommended these nurses be under the supervision of existing nursing organizations, and that before the County Society approves this measure, it first consult with these nursing organizations.

COMMITTEE ON CONSTITUTION AND BY-LAWS

Dr. Joseph Kuder was appointed on the Committee on Constitution and By-Laws to fill the unexpired term of Dr. Tracey, who had resigned at the May meeting.

NEW MEMBERS

Applications for membership were received from the following men and were referred to the Board of Censors:

R. Winfield Betts, M.D., Medford, N. J.
Freeman W. Metzer, M.D., Riverside, N. J.
Paul R. Sparks, M.D., Burlington, N. J.
John C. Voss, M.D., Riverton, N. J.

SCIENTIFIC

Dr. Howard Curtis introduced Dr. Joseph Stokes, Jr., of Children's Hospital, Philadelphia, Pa., who spoke on "Newer Knowledge Concerning Influenza". Dr. Stokes took up the recent experimental use of vaccine for the prevention of influenza. The talk gives us all hope that we will soon have a valuable preventive for the dread disease.

TOURNAMENTS

Dr. Scott was appointed to arrange a golf and tennis tournament for the society some time this month.

The meeting was adjourned, and was followed by refreshments.

ESSEX COUNTY

Venereal Disease Clinic in Orange

Members of the staff of the Orange Memorial Hospital, Orange, N. J., who are on service in the syphilis clinic, are holding a series of conferences and clinics under the direction of Dr. R. R. Sellers, of Newark.

Staff members of related services are invited to participate, and patients selected from the clinics coöperate in this plan.

Every two weeks a conference is held to discuss some particular phase of the treatment or of the control of syphilis. Coöperative clinic group studies are used as a basis for the discussion. The subjects selected by members of the staff for discussion are as follows:

Latent Syphilis—John S. Kessell, M.D., East Orange.

Cardiovascular Syphilis — Coler Zimmerman, M.D., East Orange.

Control of Syphilis—Henry deVincentis, M.D., Orange.

Late Prenatal Syphilis—Robert Jonitz, M.D., East Orange.

Cutaneous and Mucosal Relapse in Early Syphilis—Joseph E. Higi, M.D. (Acting Chief), Orange.

Asymptomatic Neurosyphilis—Harry H. Kleinberger, M.D., Millburn.

The New Jersey State Department of Health has available for distribution a limited number of reprints of the studies of the Coöperative Clinic Group referred to above, which have been published by the U. S. Public Health Service in "Venereal Disease Information". Copies of these studies may be obtained from the Bureau of Venereal Disease Control, New Jersey State Department of Health, Trenton.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The regular monthly meeting of the *Gloucester County Medical Society* was held in The Homestead, Woodbury, on September 16, 1937. Members present were Drs. H. B. Diverty, J. Harris Underwood, Dorothy Rogers, W. E. Crain, Paul M. Pegau, Ralph L. Moore, Fuller G. Sherman, Paul Burkett and C. A. Bowersox, of Woodbury; Louis Ruttenberg, Mantua; A. J. DiMarino, H. L. Sinexon, Oran A. Wood, Paulsboro; William Pedrick, Glassboro; B. A. Livengood, Swedesboro; M. F. Lummis, H. W. Wright, I. W. Knight, W. J. Burkett, Pitman; Ralph K. Hollinshed and I. N. Patterson, Westville; Don Weems and R. D. Zapf, Wenonah; C. I. Ulmer, Gibbstown, and F. G. Wandall, Clayton,—twenty-five in number.

Guests included Drs. M. W. Newcomb and Greenwald, of New Lisbon; Emma Richardson and Gilbert Palen, Camden County Society; M. B. Black, Glassboro.

NEW MEMBER

Dr. George R. Booth, of Westville, was elected a member of the Society.

SPEAKER

Dr. Marcus W. Newcomb, Past President of The Medical Society of New Jersey and Superintendent of the Fairview Sanatorium, New Lisbon, gave an interesting paper on "Early Diagnosis of Pulmonary Tuberculosis" and also exhibited x-rays of interest to the physicians.

ANNIVERSARY DINNER

The society will hold its anniversary dinner and entertainment, with the ladies as their guests, at The Homestead on October 21.

OCEAN COUNTY

Harry S. Ivory, M.D., Reporter

The regular monthly meeting of the *Ocean County Medical Society* was held at the Hotel Carlton, in Tuckerton, N. J., on Wednesday evening, May 12th, 1937, with President Buermann in the chair. The members present were Drs. Buermann, Carmona, Frazee, Schneider, Dodd, Herbener, Bunnell, Hayden, Willis, Taylor, Hogan, Obert, Halbach, Green, Goldstein, Towbin, Menge, Wittee, Hendriksen, Ivory and Sickel. Dr. Strauss, of Freehold, was a guest of Dr. Towbin. Some of the doctors' wives also dined at a supper table. These were Mesdames Halbach, Carmona, Dodd, Buermann, Goldstein, Sickel, and Mrs. Strauss, a guest.

ADDRESS BY DR. J. L. LANE

The meeting was officially opened by Dr. Buermann, who introduced Dr. J. L. Lane, of Tuckerton. Dr. Lane, who is both Mayor and Coroner of that community, gave a concise and interesting history of the founding of Tuckerton by a Quaker named Faulkenburg. And out of fifty years of practice he had gleaned many exciting experiences, some of which he related to us. We all listened with intense interest and reflection.

Dr. W. E. Dodd took this opportunity to eulogize Dr. Lane for the fine niche he has made in the medical activity in his community, and recommended that he be made an honorary member of our society. The motion to that effect was made by Dr. Dodd, and was unanimously carried.

HISTORY OF COUNTY SOCIETY

Reports from several committees were heard. Dr. Frank N. Bunnell, of Barnegat, was making progress in writing the history of the county society, and asked that all its members get in the necessary data.

ROYAL PINES HOSPITAL

Drs. Herbener and Halbach made a report on the Royal Pines Hospital located at Pinewald, five miles south of Toms River. The committee emphasized the fact that a resident physician at Pinewald has to have one year of previous interneship. A motion was adopted that the American Medical Association be requested to accept the hospital for registration.

Dr. Herbener also gave a brief report of the A. M. A. convention held at Atlantic City.

ELECTION OF OFFICERS

The following officers were unanimously elected:
President, Dr. Walter G. Hayden, Toms River
Vice-President, Emanuel M. Sickel, Lakewood
Secretary, J. Edwin Obert, New Egypt
Treasurer, William E. Dodd, Beach Haven
Reporter, Harry S. Ivory, Point Pleasant
Delegate to State Society, Adolph Tobin, Lakewood

TELEPHONE LISTINGS

Dr. Hayden brought up the utility of listing all the doctors in the county in the telephone directory under a caption "Ocean County Medical Society". After some discussion a motion was made and seconded that this matter be referred to a committee.

INTRODUCTION OF NEW OFFICERS

Dr. Towbin then took the floor and emphasized the great strides that the Ocean County Medical Society has made under the leadership of Dr. Buermann. On a motion of Dr. Towbin, the County Medical Society offered a rising vote of thanks to Dr. Buermann for his helpful efforts in assisting the fine progress made by the county society under his leadership. Dr. Buermann expressed his thanks and gratitude for the appreciation shown his humble efforts.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The monthly meeting of the *Passaic County Medical Society* was held on Thursday evening, September 9th, 1937, at the Health Centre, Paterson. The President, Dr. Fred Vosburgh, presided. Visitors, Dr. William G. Herrman, President of the State Society, and Dr. LeRoy A. Wilkes, Executive Officer, were introduced to the audience.

MEMORIAL

A resolution of sympathy and appreciation of the fine qualities of the late Dr. A. Vanderbeek, Jr., of Paterson, was adopted.

BY-LAWS AMENDED

Changes in the by-laws were read by the Secretary, Dr. Yager. These are to be voted on in November. Briefly, they are changes in the life membership; junior members to be known as associate members, and to pay annually $3.00 for subscription to the State Journal. Other changes were in the set-up of the committee to coincide with the State organization of committee activities.

CANCER WEEK

Dr. L. Shapiro, Chairman of the Cancer Committee, outlined the program for the Cancer Week Exhibit of October 11th to 15th. There will be evening sessions on these days at the Paterson Free Library. There will be exhibits of the various hospitals of the county stressing the diagnosis and operative treatment of cancer of the gastro-intestinal tract. For the laity, material borrowed from the New York Cancer Committee and the American Society for the Prevention of Cancer will be presented.

There will be three evening meetings; the first on "Cancer of the Stomach" to be presented by leaders of the Memorial Hospital of New York. Dr. Stewart will speak on the pathology; Dr. Herendeen, the x-ray diagnosis; and Dr. Peck will speak on treatment.

Another evening will be "Cancer of the Colon". Dr. Klemperer will present pathology; Dr. Farrell, of Philadelphia, will speak on diagnosis; and Dr. Frank Lahey, the surgical diagnosis.

One evening lecture for the laity will be given by Dr. Frank Adair, and his address will be "How 145,000 People Lost Their Lives".

On Tuesday and Thursday afternoons of that week there will be round-table discussions by the members of the society on cancer of the stomach and colon. This is a very complete program, and Dr. Shapiro asks the support of the physicians in this symposium. The committee is making progress in publicity, both for the laity and physicians.

ADDRESS OF PRESIDENT HERRMAN

Dr. W. G. Herrman, of Asbury Park, State President, was then introduced and gave a short talk in which he compared the changing trends in medical practice to the changes in other lines of endeavor. He pointed out that the practitioner of the nineties was an individualist, and that today coöperation among physicians was more important. The new methods of diagnosis and treatment are more costly than in the nineties, and therefore the price of medical care has gone upward. His own personal experience with the illness of his son has brought this matter to a much deeper personal realization. He said we must develop a plan for giving the people our costly goods at a proper remuneration, or we shall be cogs in the government because the public cannot pay. These problems must be solved by this organization.

He advised us to encourage the hospital insurance plan, because it will help us to collect fees. Something is then left for us. If we push this plan, we may have something to say about it. He also believed that some insurance scheme will be worked out to collect doctors' bills.

ADDRESS OF DR. WILKES

Dr. LeRoy A. Wilkes was then introduced, and he too stressed the matters of the professional and economic problems in the practice of medicine today. He congratulated the Passaic County Medical Society in the establishment of a permanent office address and the employment of a full-time Executive Officer.

SCIENTIFIC

The scientific section was opened by Dr. Norman Joliffe, Assistant Professor of Clinical Medicine at the New York University Medical College. The subject was "The Clinical Importance of Avitaminosis". Dr. Joliffe gave a short enumeration of the various vitamins, their discovery and evolution. He then confined his talk to vitamin B, because he has done more work with this vitamin, and he felt that it was one of the most important. He said there was still more to be learned about this vitamin and its relation to disease. He based his statements on several hundred patients at Bellevue Hospital, and found that polyneuritis and beri-beri were more common in this section than had been thought. Diets could be thoroughly analyzed as to their vitamin content, and the required amount of vitamin B in the diet was definitely known. Alcohol had no effect on the cause of polyneuritis, he said, but by its increased food value, and the omission of other foods, the alcoholic person developed polyneuritis because of lack of vitamin B.

OBITUARY

Dr. Andrew Bogart Vanderbeek, Jr., the son of a prominent local physician, was born in Paterson, New Jersey, March 28th, 1905, and died June 22nd, 1937. He was educated here in the public schools, later attending Princeton Preparatory School and Princeton University, graduating in medicine from Columbia University in 1933.

Dr. Vanderbeek served an interneship at the Paterson General Hospital, beginning private practice in Paterson in 1935.

Just as he was well established in practice, making rapid progress to a brilliant career, death, due to septicemia following a gangrenous appendix, overtook our colleague and friend while on a vacation in the South.

We shall miss him greatly, and our heartfelt sympathy is extended to his family. Our city as well as our society has lost a most valuable member.

THE WOMAN'S AUXILIARY

REPORTS OF WOMAN'S AUXILIARIES

The Journal assigns a department to the Woman's Auxiliaries of the counties, and the State. The Publication Committee desires to conduct the departments of County Medical Societies, and the Woman's Auxiliaries in the same manner that the editor of a local newspaper conducts his news columns.

Local reporters collect the news from local sources, and send the items to the editor, who exercises his prerogative of re-writing the stories to suit his columns. He is always looking for news, and every reporter can be assured that his stories will be used. It often happens that some items are duplications and the editor must choose which stories he shall use. He will give due recognition to small-town activites which would seem commonplace to the people of a city; and yet some of these activities are as valuable and original as the doings in larger places.

REPORTS OF MEETINGS

The principal items from Auxiliaries are those which concern their meetings. There the reports of the month's activites are given, and plans are announced for the coming month. Every auxiliary will be recognized, and its reports will be judged on the basis of their interest to auxiliaries in other counties.

Send the items to the editor, and he will put them in readable shape.

FORM OF THE REPORTS

The reports of local auxiliaries are often written on small sheets of note paper which the secretaries use in their private correspondence. They are usually written on both sides of a sheet, and in the common order of skipping from page one to page three and then back to page two, making the report difficult for the editor and the type-setter to read.

The editor suggests that the secretaries write their reports on business sheets of the standard size of eight and one-half by eleven inches; also that they write on *one side of the sheet only*. The editor can then cut up the sheets and paste the paragraphs on other sheets in the order that he wishes the typesetter to make them up in the printed form.

The editor does not care whether the reports are hand-written or typed; or whether or not they are in logical order; or whether or not the composition is rhetorically perfect. He will put the items into proper form, provided he receives the facts.

DATE OF REPORTING

Every item should be in the editor's hands by the 25th of each month. This will give him time to correspond with the reporter, and secure additional facts if necessary.

METHOD OF REPORTING

It has been the custom that each reporter shall send her items to the Publicity Chairman of the State Auxiliary, who will send them to the editor in a bunch, just as they were received—usually on a date too late to be properly edited, or referred back for additional information which may be needed to make the report clear and understandable.

The editor suggests that the secretary of each local Auxiliary send her monthly report directly to the editor.

The editor will then put them into proper form and will have them set in type. He will then send a galley proof to the State Publicity Chairman for her editing and revision, or possibly he will send proofs of some of the more important items to the county secretaries.

REPORTS FROM THE STATE AUXILIARY

The editor suggests that every issue of The Journal shall contain a report from some State officer or Chairman, written from the standpoint of the *State* Auxiliary. These reports will contain records of visits to county societies, and comments on the current activities of the several State chairmen. These should come from the Publicity Chairman, or from the President. They will be an example and an inspiration to the county secretaries.

COMPARISON WITH OTHER STATES

The Editor reads the reports of the Auxiliaries in other State Journals, and assures the New Jersey secretaries that their reports rate high. Not only are the New Jersey Auxiliaries doing excellent work, but their reports make interesting and profitable reading. The adoption of the above suggestions will place the New Jersey Auxiliaries in a high rank among the Auxiliaries throughout the nation.

The last installment of county auxiliary reports was printed in the July Journal. The remaining reports have been saved for this October Journal, when the Auxiliaries resume their meetings and the members will be the more likely to read them. It is hoped that the new plan of making the reports can be put into effect in the November Journal.

Atlantic County

Reported by Mrs. Morton Major

The *Woman's Auxiliary to the Atlantic County Medical Society* met at the Ambassador Hotel on Friday evening, May 14th, 1937.

Mrs. Lawrence Wilson was inducted as the President for the ensuing year. She made a few remarks concerning her plans for the coming year.

Other officers of the Society are:

Mrs. Charles Hyman, First Vice-President
Mrs. Robert Bradley, Second Vice-President
Mrs. Percy Joy, Treasurer
Mrs. G. Ruffin Stamps, Recording Secretary
Mrs. Allan Reick, Corresponding Secretary

Mrs. Carl Surran spoke briefly on arrangements for the entertainment for the American Medical Association convention to be held in Atlantic City in June. Mrs. Surran is Chairman of the Entertainment Committee for the convention.

The following committee heads were appointed for the coming year:

Mrs. Carl Surran, Membership
Mrs. Edward Dyer, Telephone
Mrs. Daniel Reyner, Public Health
Mrs. Louis Feinstein, Public Relations
Mrs. David Allman, Entertainment
Mrs. Clarence Whims, Musical
Mrs. L. M. Walker, Literary
Mrs. Morton Major, Publicity
Mrs. E. H. Nickman, Medical History
Mrs. Edward Harvey, Cheer
Dr. Winifred Blampin, Medical Society Adviser

This list is not completed.

Attending were Mesdames Edward Dyer, Peter Marvel, Samuel Stalberg, Ernest L. Shore, Manuel J. Mally, Samuel F. Gorson, Bernard Crane, Louis Rosenberg, Louis Feinstein, Harry Subin, Samuel Salasin, Samuel L. Winn, E. H. Nickman, John S. Irvin, William Roop, S. Eugene Dalton, David B. Allman, Ily R. Beir, Carl Surran, A. G. Merendino, Lawrence Wilson, Percy Joy, Allan Reick, Morton M. Major.

This was the final meeting of the year. The next meeting will take place in October.

At a delightful dessert luncheon Mrs. Samuel Salasin entertained members of the Executive Board of the *Woman's Auxiliary to the Atlantic County Medical Society* on Tuesday afternoon, September 21, 1937.

Mrs. Lawrence Wilson presided at the meeting. She gave a brief outline of her plans for the ensuing year. Mrs. Wilson announced her completed list of committee chairmen for the coming year:

Membership, Mrs. Carl Surran
Telephone, Mrs. Edward Dyer
Public Health, Mrs. Daniel Reyner
Public Relations, Mrs. Louis Feinstein
Social, Mrs. Harry Subin; co-chairman, Mrs. A. G. Merendino
Literary, Mrs. L. M. Walker; co-chairman, Mrs. G. Ruffin Stamps
Musical, Mrs. Clarence Whims
Publicity, Mrs. Morton Major
Welfare, Mrs. Ward Scanlon
Archives, Mrs. E. H. Nickman
Cheer, Mrs. Edward Harvey

Mrs. Wilson was selected by the Women's League to act as a member of the Reception Committee to welcome Mrs. Franklin Delano Roosevelt at a public reception for the "First Lady" when she comes to Atlantic City on October 13, 1937. Mrs. Roosevelt will speak at the Atlantic City Auditorium on that date. Her address will be "The Relationship of the Individual to the Community".

The first general meeting of the Woman's Auxiliary to the Atlantic County Medical Society will take place at the Ambassador Hotel on October 8, 1937. Dr. Robert A. Kilduffe will be the guest speaker.

Members present were Mrs. Carl Surran, Mrs. Percy Joy, Mrs. E. H. Nickman, Mrs. Robert Bradley, Mrs. Harry Subin, Mrs. Allan Reick, Mrs. Daniel Reyner, Mrs. A. G. Merendino, Mrs. Charles Hyman, Mrs. Lawrence Wilson, Mrs. James H. Mason 3d, Mrs. Samuel Salasin, Mrs. Morton Major, Mrs. G. Ruffin Stamps.

Camden County

Reported by Mrs. O. R. Carlander

Mrs. Oswald R. Carlander, of Merchantville, was elected President of the *Auxiliary to the Camden County Medical Society* May 4th at the annual luncheon of the organization held in Tavistock Country Club.

Mrs. H. Wesley Jack, of Haddonfield, was chosen President-Elect, to take office at the completion of the term of Mrs. Carlander, who succeeded Mrs. Robert S. Gamon, of Merchantville.

In addition, the following other members of the Board were elected:

Mrs. Max L. Weimann, of Haddon Heights, First Vice-President
Mrs. Lawrence Glover, of Haddonfield, Second Vice-President
Mrs. Oram R. Kline, of Woodbury, Third Vice-President
Mrs. E. Reed Hirst, of Haddonfield, Treasurer
Mrs. Harold D. Barnshaw, of Camden?, Recording Secretary
Mrs. Thomas P. McConaghy, Corresponding Secretary
Mrs. Gamon and Mrs. Reba G. Bushey, Directors

Mrs. Gamon installed the new officers immediately following the luncheon.

Committees for the new term were named also. They are as follows: Program, Mrs. A. Haines Lippincott; Public Relations, Mrs. Arthur J. Casselman; Membership, Mrs. Gordon F. West; Finance,

Mrs. William J. Scruggs; Legislation, Mrs. A. Lincoln Sherk; Hospitality, Mrs. Orris W. Saunders; Printing, Mrs. Lester R. Wilson; Public Health, Mrs. Edward C. Pechin; Widows and Orphans, Mrs. George B. German; Historian, Mrs. Joel Fithian; Sunshine, Mrs. Ernest G. Hummel; Publicity, Mrs. Lawrence Glover; Arts and Hobbies, Mrs. Merwin L. Hummel; Parliamentarian, Mrs. F. William Shafer.

Mrs. George A. Rogers, of East Orange, was honor guest at the meeting. Mrs. Rogers is President of the Auxiliary to the New Jersey Medical Society. Other guests were Mrs. Hester Ulmer, Mrs. James Hunter and Mrs. Ralph Hollinshed, all members of the Gloucester County Auxiliary.

Gloucester County

Reported by Mrs. Ralph L. Moore

The first Fall meeting of the *Woman's Auxiliary to the Gloucester County Medical Society* was held on Thursday evening, September 16th, 1937, at 9 p. m. at the Homestead Coffee Shop, Woodbury, N. J., with the President, Mrs. Don B. Weems, presiding.

The purpose of the meeting was to plan the program for the ensuing year. Mrs. Weems appointed the following committee chairmen:

Membership, Mrs. Ralph K. Hollinshed
Finance, Mrs. Fuller G. Sherman
Public Relations, Mrs. Ralph L. Moore
Program, Mrs. William W. Pedrick
Health Education, Mrs. Irving J. Stewart
Medical History, Mrs. Baxter A. Livengood

Mercer County

Reported by Mrs. L. L. Friedman

The *Woman's Auxiliary to the Mercer County Medical Society* held a social meeting on Wednesday, June 2nd, at our William McKinley Memorial Hospital in the Nurses' Residence. Mrs. C. Chester Chianese, President, presided.

The Auxiliary observed its tenth anniversary. A birthday cake, with an appropriate number of candles, was a feature of the tea served at the end of the meeting. Mrs. Alton S. Fell was the hostess, assisted by Mrs. William C. Ivins, both Past Presidents of the Auxiliary. Miss Josephine Salvatore rendered several beautiful vocal selections as part of the entertainment program. Mrs. Alma Edwards assisted at the piano.

During the afternoon some of the members were engaged in making surgical dressings for the institution, while others enjoyed cards. It was a very gay event, and a delightful time was had by all present.

This meeting marks the closing of the activities of our Auxiliary for the year. We will meet again next Fall to carry on the work of the Medical Auxiliary of New Jersey.

Somerset County

Reported by Mrs. Charles F. Halsted

The regular meeting of the *Woman's Auxiliary to the Somerset County Medical Society* was held at the Nurses' Home, Somerset Hospital, Thursday evening, June 3rd, at 8:30 o'clock. The President, Mrs. D. S. Renner, presided.

After the usual business, the President made the following appointments:

Corresponding Secretary, Mrs. A. W. Piggott
Legislation, Mrs. Josiah Meigh
Arts and Hobbies, Mrs. Lancelot Ely
Membership, Mrs. William Gray
Public Health and Public Relations, Mrs. A. F. Sferra
Widows' and Orphans' Fund, Mrs. A. Longstreet Stillwell
Program in Health Education, Mrs. E .G. Brittain

Mrs. Renner then reported at length on the State convention, after which the meeting adjourned.

Dainty refreshments were served by the nurses.



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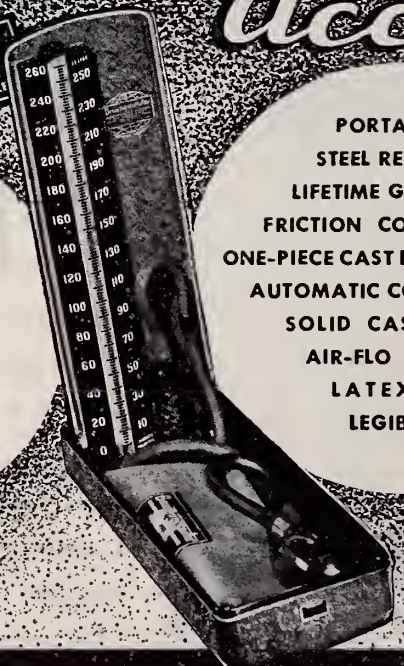
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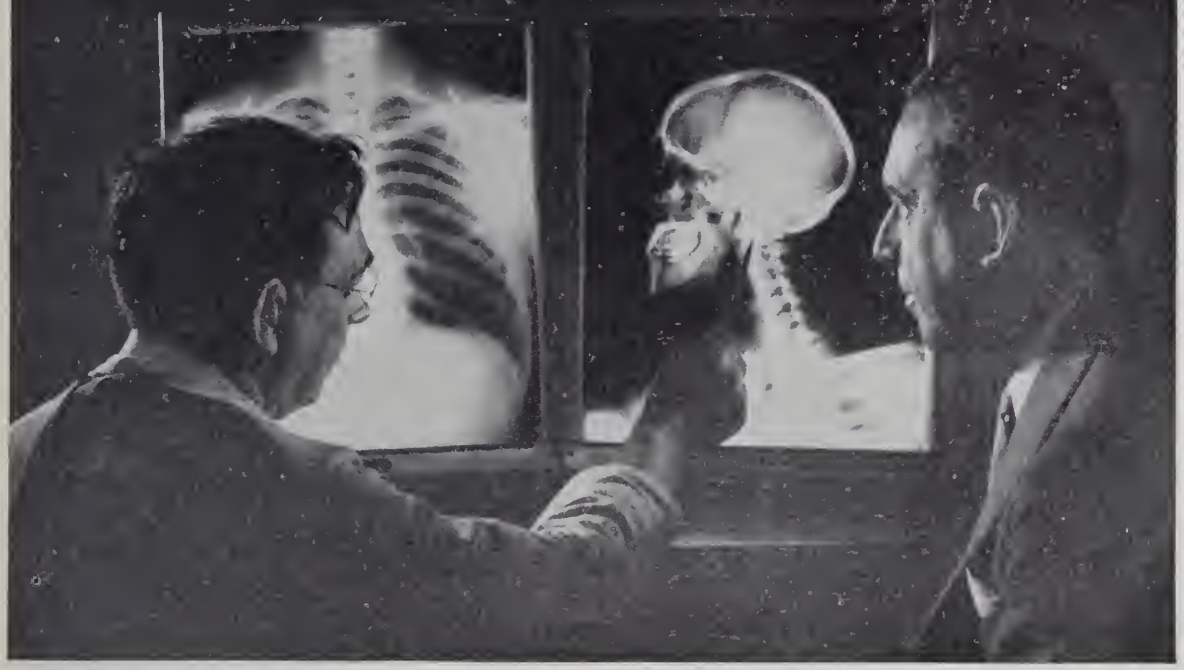
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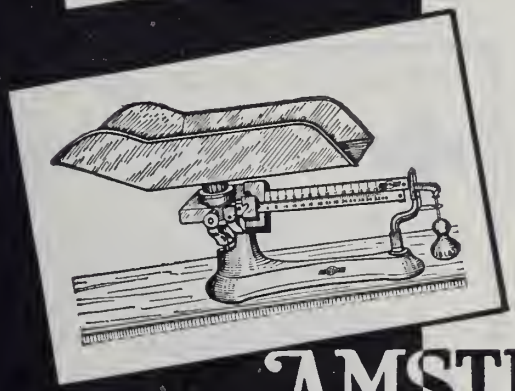
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Magnesium (Mg)	5.8	0.34
Sodium (Na)	5.6	0.33
Potassium (K)	Trace	Trace
Bicarbonic Acid, Radical (HCO_3)	43.1	2.52
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Sulphuric Acid, Radical (SO_4)	27.1	1.58
Nitric Acid Radical (NO_3)	1.8	0.11
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Phosphorus	Trace	Trace
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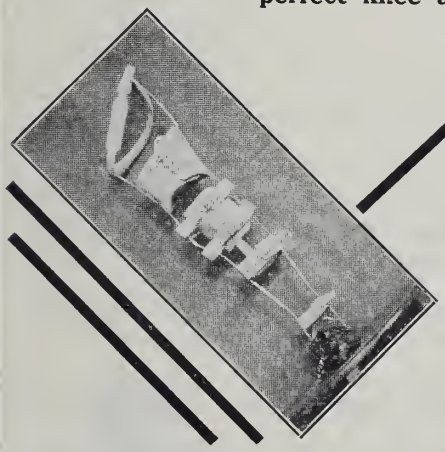
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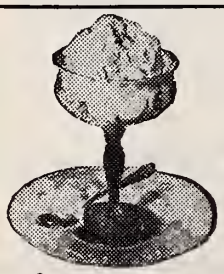
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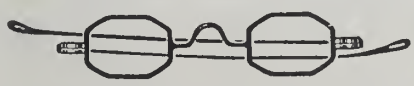
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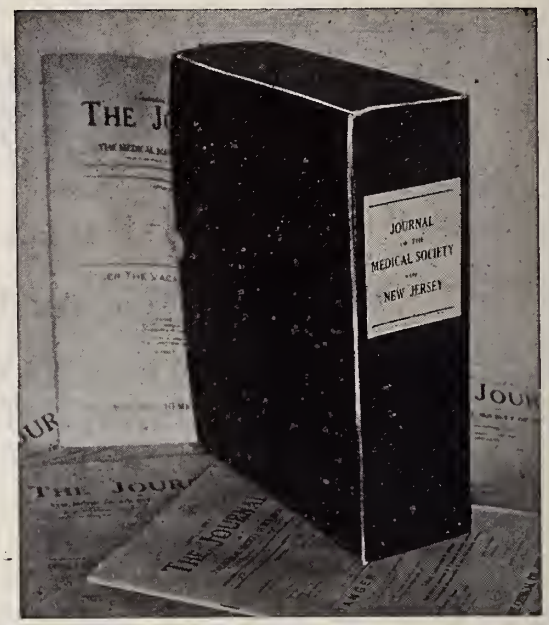
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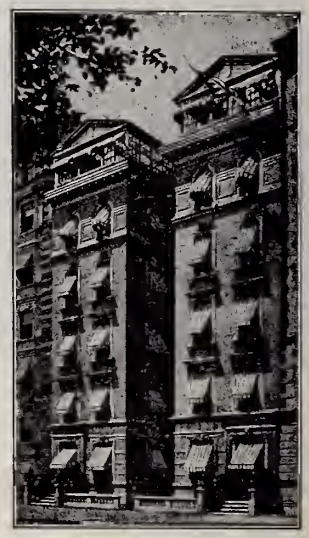
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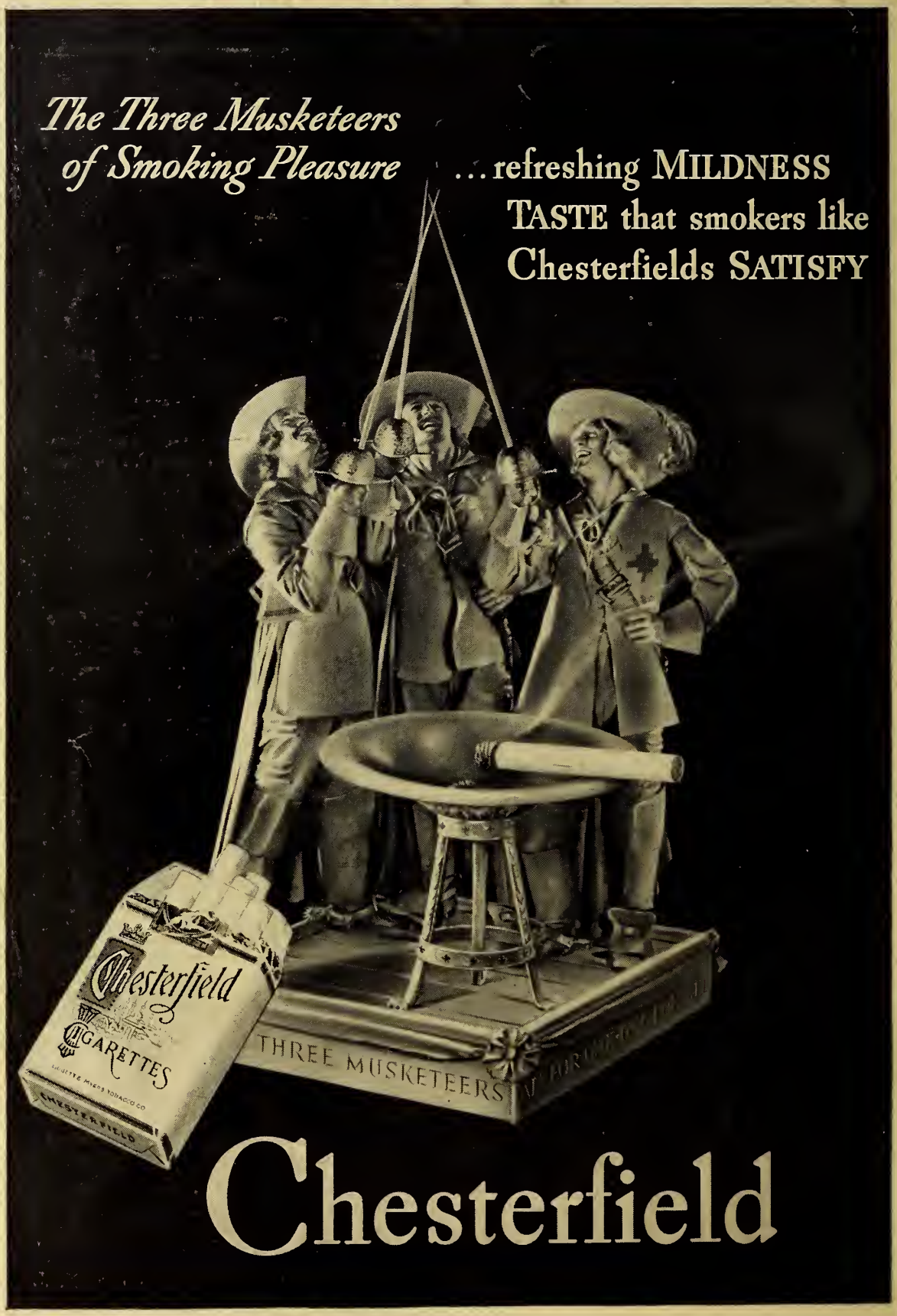
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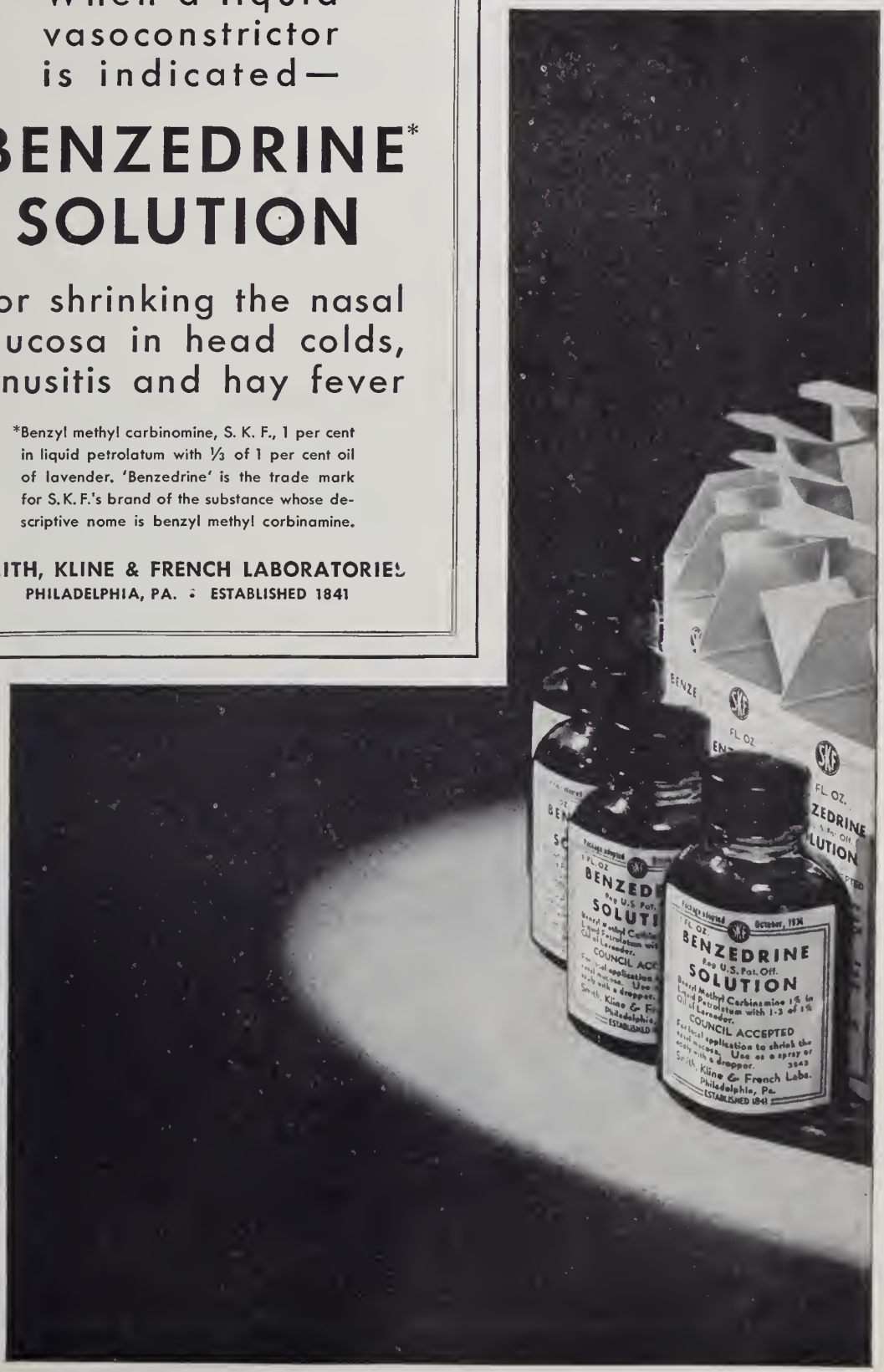
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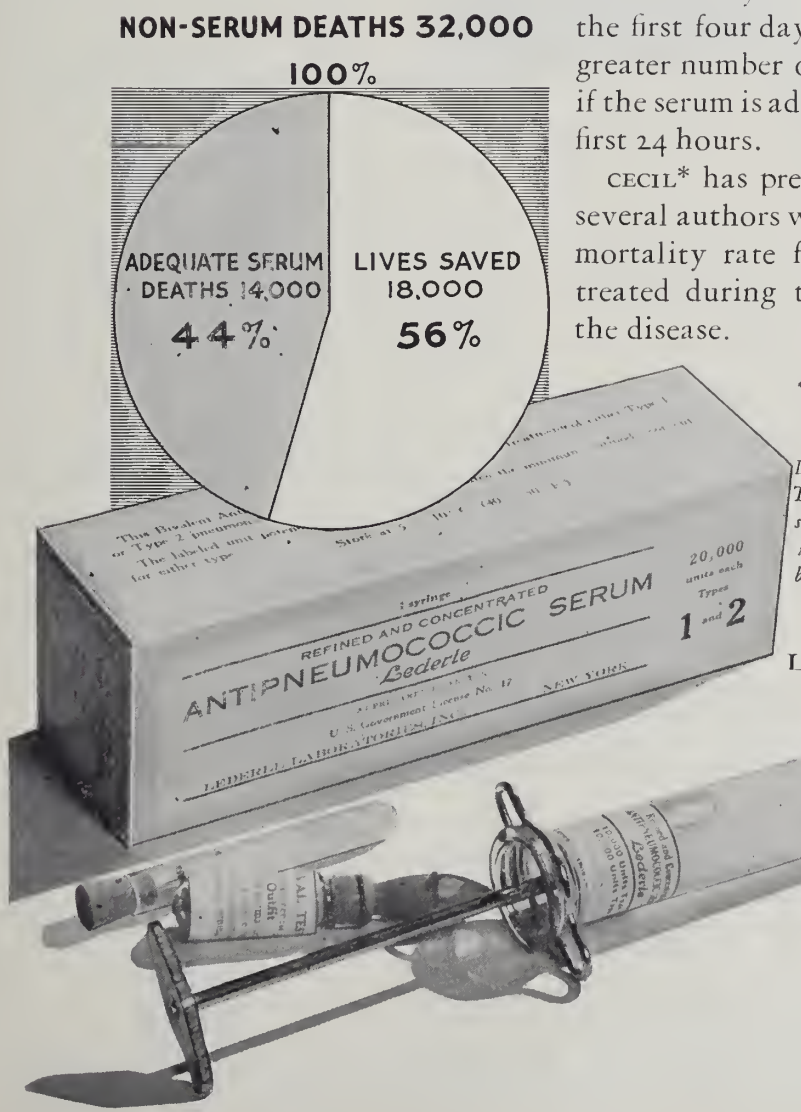
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*CECIL, RUSSELL L.: J. A. M. A., Vol. 108, No. 9, February 27, 1937.

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(1) 1935. The Lancet 228-I, 71
(2) 1936. Am. J. Med. Sci., 191, 319
(3) 1935. Proc. Soc. Exper. Biol. & Med., 32, 1930
(4) 1933. J. Lab. & Clin. Med. 18, 484
(5) 1937. The Avitaminoses Eddy and Dabldorff William and Wilkins Baltimore
(6) 1936. J. Nutr. 12, 405
1936. Ibid. 11,383
1935. Am. J. Pub. Health 25, 1340

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"As to the kind of extra carbohydrate to be added, whether lactose or maltose, I believe dextri-maltose to be better in general in cases of fat indigestion (infantile atrophy)."—*C. H. Dunn: The Hygienic and Medical Treatment of Children, Southworth Co., Troy, New York, 1917, V. 1, p. 418.*

In the treatment of decomposition, "The period of repair may be shortened by giving suitable additional food; the best, probably, being buttermilk to which carefully regulated proportions of dextrin and maltose preparations or malt soup are added."—*E. Feer: Text-Book of Pediatrics, J. B. Lippincott Co., Phila., 1922, p. 284.*

In infantile atrophy, "The carbohydrate should be increased by gradual addition of dextrimaltose.

"Malt soup or dextrimaltose (Mead's) sbould be added in teaspoonful or more doses to each feeding until the point of carbohydrate tolerance is reached."—*L. Fischer: Diseases of Infancy and Childhood, F. A. Davis Co., Phila., 1925, V. 1, p. 285.*

In the case of a premature infant, "Dried milk witb water was given, which later was changed to whole milk, 14 ounces; water, seven ounces, and dextri-maltose No. 1, one and one-half ounces. Seven feedings of three ounces each every three hours was given. Tbe above feeding was retained. The infant gained eight ounces at tbe end of the first week."—*L. Fischer: Clinical notes in a series of premature infants, Arch. Pediat. 44:227-231, April, 1927.*

In the treatment of decomposition, "As a rule it is best to start with 2 to 2½ or 3 ounces of albumin milk to the pound weight in 24 hours; the sugar to be added is in the form of a maltose-dextrin mixture. One should never delay too long in adding this."—*C. G. Grulee: Infant Feeding, W. B. Saunders Co., Phila., 1922, p. 265.*

With reference to hypotrophy, "In mild cases, the addition of dextrimaltose instead of cane or milk sugar may be sufficient to obtain a gain in weight."—*C. Herrman: The treatment of nutritional disorders in artificially-fed infants, New York M. J. 114:158-160, August, 1921.*

In athrepsia, "The carbobydrates are usually added in a slowly fermentable form, such as the maltose and dextrin compounds, which are usually started by the addition of four grams per kilogram (1/15 ounce per pound) and increased until eight grams or more per kilogram (¼ ounce per pound) of body weigbt are added."—*J. H. Hess: Feeding and the Nutritional Disorders in Infancy and Childhood, F. A. Davis Co., Phila., 1928, p. 278.*

Concerning the treatment of marasmus, "When tbe stools have become smooth and salve-like, carbohydrate, in the form of dextrimaltose, may be gradually added up to the limit of tolerance."—*L. W. Hill: Practical Infant Feeding, W. B. Saunders Co., Phila., 1922, p. 281.*

In the feeding of prematures, "As soon as there is a hesitation in the gain in weight, dextrimaltose No. 1 is substituted for the dextrose, in the same amount in the mixture, with almost invariably a gain in weight."—*F. B. Jacobs: Relation of irradiated food substances and ergosterol versus cod liver oil in childhood nutrition, Pennsylvania M. J. 35:164-167, Dec., 1931.*

"A spasmophilic baby on bottle feeding should receive a limited amount of milk—a pint, or at the most 24 ounces in the 24 hours—to which cereal gruel and some form of sugar is added, preferably one of the malt dextrin preparations; also the early addition of other foods than milk to the baby's diet."—*M. Jampolis: Infantile spasmophilia, Interstate M. J. 25:652, Sept., 1918; abst. Arch. Pediat. 35:691, Nov., 1918.*

In cases of malnutrition and indigestion, "The appetite improves rapidly, and the stools soon become normal in appearance, if the sugars are intelligently prescribed. By this I refer to proper proportions of dextrin and maltose. When there is a tendency to looseness, I have used the preparation known as 'dextri-maltose,' for the extra carbohydrates; . . ."—*M. Ladd: Further experience with homogenized olive oil mixtures, Arch. Pediat., 33:501-512, July, 1916.*

In pyloric stenosis, "With low dextrose tolerance, a maltose dextrin preparation may be added in whole or in part. Even where the dextrose is well tolerated and gain in weight has ceased, impetus to the weight ontake may be given by the addition of a maltose dextrin preparation."—*D. J. Levy: Pyloric stenosis and pylorospasm of infancy with especial reference to medical treatment, J. Michigan St. M. S., 21:166-170, April, 1922.*

Witb reference to the treatment of diarrhea, "After several days, 2% to 3% of a maltose-dextrin preparation may be added (Dextri-Maltose). This is preferable to the easily fermentable lactose or cane sugar."—*F. Lust: The Treatment of Children's Diseases, J. B. Lippincott Co., Phila., 1930, p. 145.*

In dyspepsia, "The carbobydrate must not be allowed to exceed 3 per cent. Dextri-maltose is the most suitable sugar."

In the treatment of decomposition (atrophy, malnutrition, marasmus), ". . . when there has been obvious improvement, dextri-maltose is gradually increased from 3 to 5 per cent."—*B. Myers: The nutritional disturbances of infancy, Brit. M. J., 1:1079-1083, June 21, 1924.*

"The treatment of artificially fed children in the first of these groups consists in putting them on a low fat dietary, and giving them carbohydrate in the form of one of the less fermentable sugars—e.g., dextrimaltose."—*L. G. Parsons: Wasting disorders of early infancy, Lancet, 1:687-694, April 5, 1924.*

In the milder cases of inanition, "Regulation of this disturbed organismal balance is obtained by the addition of carbohydrates, while fat and casein are reduced. For this purpose dextrimaltose and flour are better than the ordinary sugars, since they are more slowly absorbed and have greater efficacy in their powers of controlling the flora in the large intestine."—*W. J. Pearson and W. G. Wyllie: Recent Advances in Diseases of Children, P. Blakiston's Son & Co., Phila., 1930, p. 116.*

In intestinal intoxication, "I have had more experience with dried skimmed milk in which 2 to 5 per cent dextrimaltose, barley or rice flour has been cooked, and the mixture subsequently fermented by lactic acid bacilli or soured with lactic acid, than with any other food except protein milk."—*G. F. Powers: A comprehensive plan of treatment for the so-called intestinal intoxication of infants, Am. J. Dis. Child., 32:232-257, August, 1926.*

Regarding the treatment of tbe marantic infant, "After the intolerance to sugar has been overcome a carbohydrate, preferably Dextri-maltose, may be added."—*C. S. Raue: Diseases of Children, Boericke & Tafel, Phila., 1922, p. 427.*

In spasmophilia, "Dextri maltose is the best sugar to use in tbese cases, in the proportion of 6 to 8 per cent."—*J. H. Reading, Jr.: Spasmophilia, Hahneman. Monthly, pp. 403-411, July, 1922.*

In the treatment of atrophy, "If the baby continues to improve, tbe next step in the treatment is to add to the milk one of the less fermentable carbohydrates, such as dextrimaltose; . . ."—*H. Thursfield and D. Paterson: Diseases of Children, William Wood & Co., 1929, p. 105.*

"I also find dextrin-maltose an excellent addition to albumin-milk when the first object of that food has been achieved and a gain in weight is desired, in this way I have succeeded in feeding albumin-milk far beyond the period usually advised, with highly gratifying results."—*F. L. Wachenheim: Infant-Feeding; Its Principles and Practice, Lea & Febiger, Phila., 1915, p. 158.*

"Dextri-maltose has been substituted for lactose not infrequently, when the tolerance for the latter continues low."—*I. H. West: Low fat, high starch evaporated milk feeding for the marasmic baby, Arch. Pediat. 48:189-193, March, 1931.*

"Malt sugar is indicated when others fail to produce a sufficient gain, or when malassimilation of fat is evident."—*O. H. Wilson: The role of carbohydrates in infant feeding, Southern M. J. 11:177, March, 1918; abst. Arch. Pediat. 35:447, July, 1918.*

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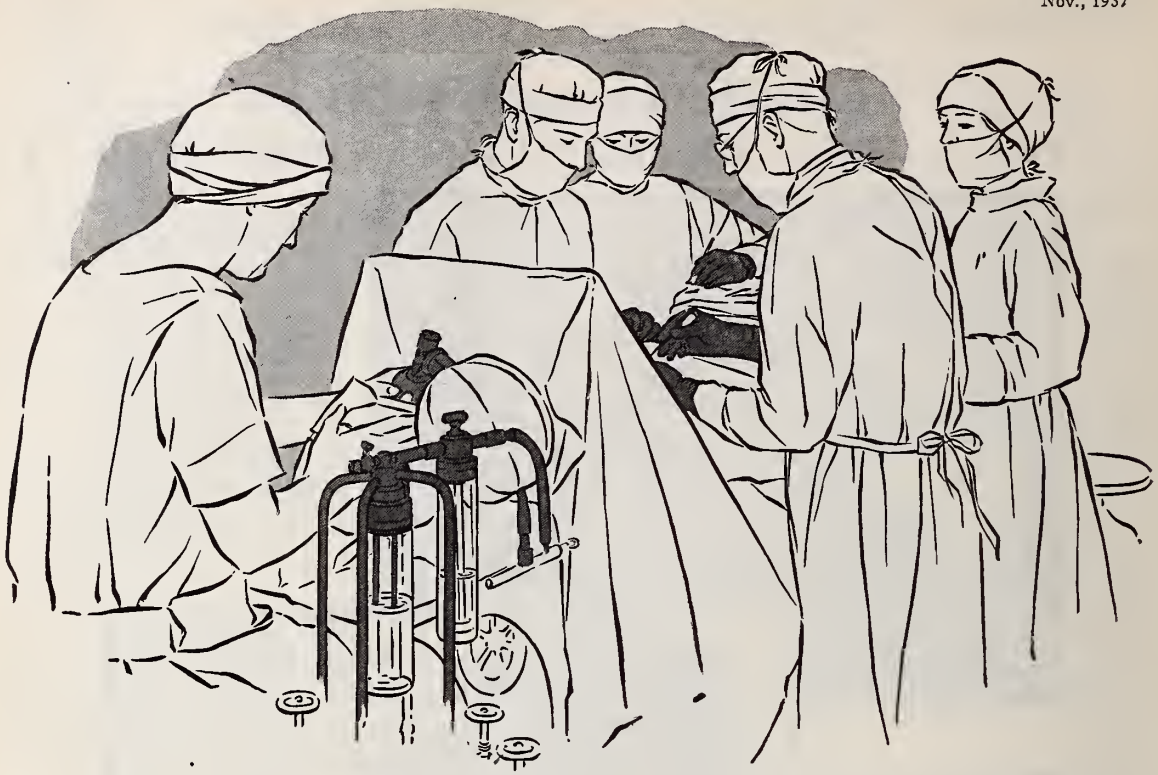
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EDITORIALS

"First Remove the Beam from Thine Own Eye"

The August number of the Readers Digest contains an article entitled "Optometry on Trial". The author, Roger William Riis, in masterly style describes how patients with normal eyes were fitted with glasses by a number of different optometrists with prescriptions that varied widely, while those with defective vision who had previously been examined by thoroughly competent occulists, received considerably worse treatment from optometrists than did normal patients, not in one section of the country but in widely different regions. He went on to describe how the eye signs of a constitutional disease, which any competent occulist would recognize, were completely missed. This article has received wide discussion not only among the medical profession but among the laity. It will accomplish far more toward seeing that this bespectacled nation receives proper eye examinations than any amount of shouting from the housetops indulged in by the occulists themselves or the medical profession.

We cannot thank this author and the Readers Digest enough for the wholesome publicity which they have given to this subject. But, if we wish to take advantage of this unasked for, unsolicited, and unpaid for help, we must first put our own house in order.

Patients have been referred by licensed physicians to optometrists for eye examinations, to commercial laboratories for x-ray examinations, to so-called pathological laboratories run by technicians, and to non-medical men for physio-therapy and manipulation. There is no royal road to health, and the fare is not cheap. First-class, adequate medical attention by the general practitioner or in the specialties, is costly. Somebody must bear that cost. In many cases the physician partly bears it by reducing his fees. In other cases the community contributes; but no matter who pays, it is still costly goods. So-called cheap medical care is often most expensive in the time that may be lost and the damage that may be done, or in the failure to recognize the true road to renewed health and strength. No one should recognize this better than medical men. There should be no false economy on their part to try and save their patients a few cents or dollars by employing cheap assistants or by referring their patients to those poorly qualified to give auxiliary services. In some few cases,

no doubt, this reference has been deliberate with the idea that, if the service costs less, the patient would have more money left to pay the referring physician. We might as well admit that this has sometimes been the motive.

For the benefit of both the patient and the ultimate good of the medical profession, medical services of all kinds should be in the hands of medical men themselves. Then will we really be entitled to such help from the laity as we have received in the above-mentioned article.

The second article, "Optometry on Trial", appears in the October issue of the Readers Digest.

Public Health in Private Practice

The modern practice of medicine in New Jersey has developed into two great divisions, —private practice, and public health.

By private practice is meant that form of service which is rendered by individual doctors to individual patients who seek their services. This form of practice has had two limitations:

1. The inability of many victims of long-continued diseases to carry out the measures which are necessary for the diagnosis and treatment of their ailments.

2. The lack of direct means of treating many common diseases, such as arthritis and hard arteries.

The great advances in the science of medicine, and the development of the social consciousness of the people, have now made the practice of public health and preventive medicine obligatory upon the medical profession. The essential characteristic of the practice of public health is the active participation of all classes of people in measures for diagnosing and treating diseases. Sickness is no longer a private matter which concerns only the individual patient and his immediate family. The former fatalistic attitude of both physicians and the people of a community toward the victims of chronic diseases is now being replaced with a justifiable optimism regarding both the cure and the prevention of many diseases which were formerly incurable in fact as well as theory.

Physicians have always been anxious to eradicate the diseases from which they have derived the major part of their livelihood. They have been almost entirely successful in respect to three major scourges—malaria, typhoid fever, and smallpox—owing to their militant leadership and the enlightened coöperation of the people themselves in applying preventive measures.

FIVE PUBLIC HEALTH PROBLEMS

The practice of public health and preventive medicine by every physician is now more essential than ever before, especially in dealing with the five diseases of tuberculosis, cancer, venereal disease, pneumonia, and chronic diseases of the heart and blood vessels. The eradication of these five diseases will depend primarily on the personal interest which every physician takes in every case that comes to him for advice—as all do at some time during their sickness. The eradication also requires the physician to take measures to secure the impersonal participation of the people themselves in providing the means for their diagnosis and treatment. Public provision is available for tuberculosis patients; public provision for cancer cases is now under way; and anti-venereal measures are now being made available. Anti-pneumonia measures are now under development, and will soon be available to every family doctor; and chronic diseases of the heart and arteries are now being studied intensively.

The treatment and prevention of each of these five diseases belongs primarily with the family doctor. The manual on the Practice of Preventive Medicine that was issued by The Medical Society of New Jersey last March was prepared for the major purpose of informing family doctors of the facilities for assistance which are available to him in fields of preventive medicine and public health.

Usefulness of Medical History

Historical articles always have an appeal, especially those which trace the development of existing plans of organization. The members a century ago discussed the identical problems that confront the medical profession today; and their earnest efforts to solve them are useful precedents to be considered today. It is gratifying that most of the plans of today have been tested and tried years ago. For example, the necessity of public support was felt in 1769 and 1770 when The Medical Society of New Jersey asked the legislators for the first law regulating the practice of medicine. The first appeal by the doctors was counteracted by a petition from certain people who were influenced by quacks to send signed petitions against the law. The medical committee then got an overwhelming number of signatures to a petition in favor of the law; and the legislators heeded it by passing the Medical Practice Act of 1772.

We are doing the same thing today as the essential procedure in getting a law passed. The reason that the doctors were successful in 1772 was that they were active in civic affairs, and held offices ranging from justices of the peace to members of State Legislatures, and to judgeships, both county, state, and national.

The Anti-Tuberculosis Campaign in New Jersey

The organized campaign against tuberculosis has undergone an evolution in three stages.

At the inception of the work in the first decade of the twentieth century, the great problem was the detection of advanced cases, and their isolation and treatment in public sanatoria. In those days tuberculosis ranked first among the causes of death, claiming over 100 victims annually in each 1000 of the population. The work was conducted along epidemiological lines which applied to all communicable diseases. The results were spectacular, since in the course of two decades the death rate was cut to one-half or one-third of its former figure. In fact, over-optimistic expectations were aroused, even to the publication of the slogan "No untreated cases after 1925".

THE SECOND PHASE

The second phase of the anti-tuberculosis work began in the decade of the twenties, with a widespread building of public sanatoria, the establishment of diagnostic clinics, and the formation of tuberculosis societies in every section of the country. But one of the most important advances was the response of physicians, and especially family doctors, to instruction in the early diagnosis of the disease.

THE THIRD PHASE

It was soon discovered that what was sometimes called the "Irreducible minimum" seemed to be reached. As in all other communicable diseases, it was found that the remaining major cause of infection was the mild, open case who was unaware that he was giving off virulent bacilli. How to discover and treat these so-called mild cases was the third great problem in tuberculosis control; and the institution of newer methods of approach constituted the third and present phase of tuberculosis prevention and control, which is still in the process of its development and full fruition.

It had been discovered that, although the general mortality from tuberculosis had been effectively reduced, yet it had not been lowered among young persons in their teen ages. The newer work was therefore organized along two lines:

1. The discovery of cases among young persons in the teen ages.

2. The discovery of the sources of their infection.

The most practical avenue of approach to the problem was the *high school,* for the education laws compelled the school attendance of all youths up to the age of sixteen.

The campaign for the discovery of cases was based on the utilization of perfected means of detecting mild evidences of the disease, especially the tuberculin test, and the modern x-ray machine and film. To apply the modern tests

required the active coöperation of many groups of citizens:

1. Physicians, especially general practitioners and family doctors.

2. Public officials, especially school boards, health officers, voters, and citizens generally.

3. Anti-tuberculosis organizations and welfare societies.

Practical methods of work were developed in Jersey City, Newark, and other large centers of population; and practical results were soon demonstrated.

Reports of excellent results attained were published, among them being that of Bergen County,—a metropolitan area which had many of the characteristics of a semi-rural community, with a density of population of 160 per square mile. Its experience demonstrated that the work could be conducted successfully and with popular approval in communities outside of large cities.

The annual meeting of the New Jersey Tuberculosis League, held in New Brunswick on October 22, was devoted largely to a description of the methods of detecting undiscovered cases among high school students and teachers, and especially to arousing civic groups to their duty of educating both public officials and taxpayers regarding the necessity of their full cooperation.

This new phase of the work has the active support of The Medical Society of New Jersey and the county societies, and interest in it is rapidly developing among all classes of people. Its result in the near future will undoubtedly be to cut the mortality from tuberculosis to less than half its present rate.

It was a great feat that the first phase of anti-tuberculosis work reduced the mortality rate to one-half its former figure. The second phase of the work again cut the remaining mortality rate in half, and the third phase is confidently expected to cut it in half again. If this proportion of reduction continues, there will be far fewer cases in any given community, and the danger will be that the small number of new cases will lull the people into indifference. The great work of the New Jersey Tuberculosis League will be to keep the problem of the ultimate eradication of the disease before the people.

Density of Population

The term "Density of Population" has various meanings and implications in public health, as in transportation, education, and all other human relations.

People usually think of New Jersey as thinly settled, and approaching the rural in its characteristics, yet enjoying the advantages of a great metropolitan center on each border. However, New Jersey is in fact one of the most densely populated regions of the world, as is shown in the accompanying chart.

The density of population of New Jersey, and the ease of travel throughout its wide area by railroad, automobile and bus routes, are great factors in promoting the efficiency of The Medical Society of New Jersey.

DENSITY OF POPULATION
(Population per Square Mile)
Census of 1930

	Area Sq. Miles	Population	Density	Order in Density
New Jersey ...	7,514	4,041,344	538	4
Connecticut	4,820	1,606,903	333	10
Delaware	1,965	238,380	121	17
Massachusetts..	8,039	4,250,104	528	5
Rhode Island ..	1,067	687,497	644	2
New York	47,654	12,588,066	262	11
Pennsylvania ..	44,832	9,631,350	213	12
England	50,874	35,678,530	700	1
Scotland	30,405	4,882,288	160	15
Ireland	31,849	4,221,992	132	16
British Isles....	113,128	44,782,710	397	7
Holland	13,220	7,832,175	592	3
Japan	147,652	62,938,200	441	6
Italy	119,710	41,508,000	347	8
France	212,659	41,020,000	191	13
Germany	181,723	63,178,619	342	9
India	1,805,332	318,942,480	177	14

ORIGINAL ARTICLES

THE UNION COUNTY MEDICAL SOCIETY

PRESIDENT'S ADDRESS, OCTOBER 13, 1937

By Elmer Peter Weigel, M.D., Plainfield, N. J.

In keeping with the wise and generous traditions of the Union County Medical Society, the retiring President is expected to give an account of his stewardship in the form of an annual address. Fortunately for him it is not open for discussion.

I can recall, in the not too distant past, when the presidential paper was on a scientific subject; but more recently my immediate predecessors have chosen to speak on the economic questions which confront the profession. I will briefly take stock of our present economic status, and offer some suggestions, and shall I say hopes, for our future well-being.

The past year has not been altogether a placid one, and although many of the problems confronting us still await final solution, I think we can point with pardonable pride to our accomplishments. Although many of the results of the depression are still with us, the economic condition of the profession on a whole is better. Fewer patients are on relief; a larger number are able to finance, in some degree at least, their medical costs; and hospital insurance has spread to include more of our institutions, thereby leaving a larger percentage of the patient's dollar available for medical fees.

MEDICAL-DENTAL SERVICE BUREAU

The Medical-Dental Service Bureau has been put on a much firmer basis, and has been self-sustaining for the past eight months. The success of this undertaking I look upon as one of the outstanding accomplishments of the past year. It will prove to be of inestimable value to the physicians of Union County and their patients. I also feel that it will go far to build up the respect and confidence for organized medicine in the mind of the laity, which is so badly needed.

The Bureau, as you know, was one of the ways in which organized medicine planned to make adequate medical care available for those of lesser income, and in this way to combat the often-made assertion that our present set-up in private practice does not offer such facilities. I most earnestly recommend the facilities of the Bureau to all of those who have not as yet used them.

NUMBER OF MEETINGS

It would seem to me that the best interests of the Society would be served if we were to have at least six regular meetings each year. This would give more time to transact the large amount of necessary business that confronts us today. It would also enable all the committees to thoroughly bring to the attention of the Society as a whole, the numerous problems which come up for definite action. In addition to this, more time would be available for an enlarged scientific program, which, I am sure, all would welcome.

HEADQUARTERS OFFICE

It is also quite possible that your new officers may find a way of employing at least a part-time secretary to care for the growing routine work of the society. Such an individual could be located in the same office as the Medical-Dental Service Bureau, which would then become the official office of the Union County Medical Society. I feel that during the past year our organization has become much stronger. There seems to be a greater interest taken by more men in the things that concern us all as a profession. The attendance at the meetings has improved. The interest shown by the younger men is very encouraging and must be productive of ultimate good.

RELATIONS TO THE STATE MEDICAL SOCIETY

To some extent this increased interest may be due to the improved organization and broader policy assumed by the State Medical Society. Representatives of our own County Society have taken an active part in the affairs of the State Society, and have brought some of that enthusiasm and alertness back to our County Medical Society.

Union County has been honored by The Medical Society of New Jersey in having one of its members, Dr. Watson B. Morris, elected to its Second Vice-Presidency during the year. We have also been given increased representation on the State Welfare Committee.

INTEREST THROUGH ACTION

The increased number of committees necessary to carry on the broadened program have

given opportunities for service to more men. This, I am sure, is one of the best ways to acquaint our members with the problems confronting us, and it should stimulate in them a desire to be active in the affairs of the County Medical Society.

At this point, I wish to state very definitely that I feel a very large part of what we accomplished during the past year was due to the untiring efforts and splendid coöperation of all the committee chairmen and their members. I am convinced that in the success of any program, or activities, that this or any other County Medical Society may undertake, one-tenth rests with the officers, and the other nine-tenths with the rank and file of the membership, a large number of whom serve on the various committees.

INTERNAL HARMONY

There has crept into our Society in the past a feeling on the part of some of our members that possibly the interests of all were not receiving equal attention. This type of reaction is not unusual in organizations such as ours, particularly as the membership grows. I am not at all sure but that it is a very healthy reaction in any organization from time to time. For a while it seemed as if the society itself might suffer from this difference of opinion. However, I am very happy to say this has not been the case. All members have had an opportunity to express their views freely; and as a result the society today adequately represents the opinion and interests of all of its members. I feel, however, that it is in order at this time to say a word of caution to those who find themselves in positions of responsibility because of the broadened organization which exists in the society today. Unless you are willing to consider the interests of those who have given ground that you might serve, with the same generosity and fidelity that you demanded of them, you will soon find yourselves confronted with insurmountable difficulties. The inevitable price of authority is responsibility and devotion to one's trust. If accepted in that spirit, no man can render a greater service.

BENEFITS OF MEMBERSHIP

Such a position, however, only becomes most effective when we number among our membership a much larger percentage of those practicing ethical medicine. During the past year our membership has increased by approximately twenty members. There are still, however, many who should be included, and I would strongly urge that the incoming officers bend their efforts in this direction. Our strength and effectiveness will increase in direct proportion to our membership.

A great deal has been said and written of late about the rights of the individual doctor. Every effort has been made by the State and County Medical Societies to preserve for the practitioner all his prerogatives against encrouchment by government and other socially-minded organizations. Frequently, however, this same practitioner for whom organized medicine has conducted this campaign is woefully lacking in the knowledge of the more recent medical discoveries. If he is to be worthy of all the efforts that are being made in his behalf, increased opportunities for post-graduate instruction must be made available for him.

SOCIALIZED MEDICINE

I dare not conclude this paper without making some reference to compulsory health insurance, which seems to be the aim of our Federal Government. These schemes all tend to relieve the individual of responsibility and increase the length of his illness. In short, it becomes profitable for him to be sick. Its outstanding defect is that it divides the practice of medicine into two classes, and the effectiveness of such service depends on the economic status of the patient. A superior type exists for the well-to-do; but practice in the lower economic groups becomes one of a brief consultation, scanty history and examination, and usually a bottle of medicine. I am convinced that our best interests do not lie in compulsory health insurance, and feel that the Medical Profession as a whole should oppose it.

In these troubled days, when materialism has grown great about us, temptation to self-interest, carelessness, and sharp practices often confront us. These can be overcome only by a devotion to the principles and ideals of the Hippocratic Oath to which we have all subscribed. It requires persistent effort to develop in all our professional contacts that sympathetic understanding of ourselves, our fellows, and our patients which makes for integrity of character and personality.

APPRECIATION

It is difficult for me to tell you how much I appreciate the honor of having been your President. This past year has been a most interesting and stimulating one for me. If during my period of office the good work of the Union County Medical Society has been maintained or advanced ever so little, I shall feel amply rewarded for any efforts I have made.

THE ACADEMY OF MEDICINE,—ITS EDUCATIONAL VALUE TO THE DOCTOR AND THE PUBLIC

By Max Danzis, M.D., Newark, N. J.

The Presidential Address delivered at the Annual Meeting of the Academy of Medicine of Northern New Jersey, May 20th, 1937

If I am found wanting in my expressions of appreciation of the honor you have bestowed upon me in electing me your President, it is because of a feeling of humility and a sense of personal inadequacy, rather than of self-sufficiency.

In attempting to put down in a few simple sentences my reaction and gratitude to you for having placed in me your confidence to lead such an organization as this, I can simply say that it is no small honor to be elected by one's colleagues to an office of trust and position in any medical organization, but it is a real distinction to be entrusted with guiding the policies and assuming the responsibilities of a medical educational institution such as the Academy of Medicine of Northern New Jersey.

I wish to express my profound appreciation to the Chairmen and Secretaries of the various sections, and the members of other committees, of the fine manner in which they have carried on their work. The Section programs were well planned, the material was of an interesting and diverse medical nature, usually presented by interesting speakers, and the attendance was, with a very few exceptions, most gratifying.

I am extremely grateful for the coöperation I have received from the Council and the Board of Trustees. Our incoming President was most helpful, and our Secretary fulfilled his duties with great credit.

DEVELOPMENT OF ACADEMIES

The subject of my paper, as indicated by its title, can be best developed by reviewing briefly the development of the early scientific societies which paved the way for modern scientific organizations, including those of medicine.

We have traversed many scientific barriers since the first Academy was established in Athens in the Fifth Century B. C. It was a gathering place of the intellectually-minded disciples of Plato. Here they could discuss the various problems that confronted them during that early period.

Between that period and that of the sixteenth and seventeenth centuries, when the revival of learning took place, there was very little progress made in the development of scientific societies. Even during the early part of the seventeenth century, the spread of scientific knowledge was left entirely to a few exceptionally gifted people who were possessed of an unusual courage and determination to search after new scientific truths. These men of outstanding genius were scattered throughout Europe, and it was through their influence that experimental science was developed. Under their leadership science assumed an entirely new aspect. Most of these pioneer scientists scattered throughout Western Europe, because of lack of modern methods of communication, worked independently of one another. Each individual scientist attracted to himself a very limited group of people who were interested in his teachings, but gradually the enthusiasm for experimental investigation led many of those who had a common interest to enter into some form of affiliation, and thus the scientific society was born.

It is said that "it was the task of the seventeenth century to introduce experiment into science". Before the development of these various scientific societies, religion and national bias governed the universities. The University of Paris (seventeenth century), one of the foremost in Europe, numbering 30,000 students, admitted only those of the Catholic faith, and one of the most important functions of the Rector was to impress the students with their religious duties.

All progress is usually initiated by a few far-

seeing, courageous individuals who have an abiding conviction in a certain cause. Progressive scientific teaching in the European universities was instituted very slowly, but surely, through the efforts of a few such courageous men who have risked scholastic ostracism, banishment, imprisonment, and even death. Many of these progressive scientists and thinkers were not affiliated with any university.

Men like Bacon and Boyle in England, Leeuwenhoek in Holland, Liebnitz and Kepler in Germany, Descartes and Pascal in France, were all free lancers. They insisted that university instruction should be based upon original observations through laboratory procedures established for that purpose. They stressed the necessity of freedom of conscience in the pursuit of philosophical and scientific studies.

The motivating force behind all these early societies was to encourage the development of experimental science. They made it possible for the scientists, either as individuals or in groups, to carry on their investigations in many subjects, particularly in natural sciences. They uprooted many superstitions and broke loose from false traditions; and by adopting the experimental method of the laboratory, they put science on a solid foundation.

One of the most influential scientific societies established in the seventeenth century was the Academy del Cemento, which was organized in Italy by a group of men, mostly pupils of Galileo and Torricelli. They brought into this organization the knowledge of physics and experimental skill. However, most of their interests centered around the study of meteorology, mathematics, and optics. Very little or no attention was given to the subject of medicine. On the other hand, the program of the Royal Society of England, which was also organized in the seventeenth century, was a more comprehensive and practical one. It included trade, commerce, and manufacture in its transactions. Many physicians of prominence during that period were among its organizers. They were the physiologists and anatomists of this society. The program included the "right to demand, receive, and anatomize the bodies of executed criminals". Considerable experimental work in physiology and anatomy was performed in the private laboratories of some of its members. The study of microörganisms was promoted, experiments in blood transfusions were carried out, and an actual transfusion of blood from the jugular vein of one dog into that of another was given in 1766.

Mathematicians, philosophers, physicists, and parliamentarians manifesting a special interest in science were the organizers of the French Academy of Science. This organization had the advantage over the two previously mentioned, because it received recognition by the King, and the cost of its maintenance was defrayed by the King's treasury. They paid particular attention to the study of animals, plants, and human dissection, and for that reason, probably had a great influence in the development of the modern medical scientific academies.

A society of particular interest to the modern doctor, which is probably a forerunner of the present-day medical academies, was the one organized by a group of physicians in Germany during the seventeenth century,—the Collegium Naturae Curiosorium. Its main purpose was to publish scientific papers pertaining to medicine based on the result of original work done by its members. Every licensed physician was invited to join. This is the first example of a society that was purely democratic in its organization, and utilitarian in its purpose.

One of the most outstanding scientific societies in Germany during the seventeenth century was the Berlin Academy, which owes its origin to Gottfried Willhelm Von Liebnitz, whom the Emperor Frederick called "a whole academy in himself". He was primarily a philosopher, mathematician, and scientist. He was one of the first to advocate the inclusion of medical science in the university curriculum. He stressed the study of anatomy, chemistry, botany, and zoology. He believed that all discoveries made in physiology and chemistry should be applied to increase the comforts of humanity in general. Under his influence, there arose a most refreshing and stimulating method of

teaching in every department of learning, including that of medicine.

It is of interest to note that even in a country as backward as Russia was during those days, Peter the Great established an academy of science in St. Petersberg in 1724 which is still in existence. In America, the two outstanding scientific societies organized during the same period were the American Philosophical Society, founded by Benjamin Franklin for "promoting useful knowledge", and the Academy of Arts and Sciences organized in Boston.

The impetus given to the development of science by all these scientific societies was a far-reaching and lasting one. As a result of these activities, there followed a gradual but steady development of the various specialized forms of learning, and the establishment of special scientific societies of which our Academy is an example.

DEMOCRACY OF ACADEMIES

There is a marked contrast between the older exclusive scientific societies, whose interest centered mostly in abstract science, and the younger organizations formed for the dissemination of certain well-established scientific facts, medical or otherwise. The old societies represented only the aristocracy of learning; the younger ones are founded on a purely democratic basis.

Our Academy is an educational institution whose main object is the dissemination and advancement of the art and science of medicine. Its purpose is that of medical instruction. There is no intent at exclusiveness. It makes no attempt to establish an aristocracy of learning. It exerts all its efforts towards a diffusion of medical knowledge among the profession. Our doors are wide open to every ethical practitioner of medicine, who, if he is a true devotee to the healing art, may come to enjoy all the educational advantages which the academy has to offer.

I believe we thoroughly conform to the modern accepted definition of the word "academy", which is defined as a "corporate body, having for its object the cultivation and promotion of literature, science, and art, for the pure love of these pursuits, with no other motive".

EDUCATING THE DOCTOR

What does the Academy do for the education of the doctor?

We are living in an age where rapid change is a normal condition of our lives. In order to carry on our functions as useful members of a profession, we must undergo a continuous adaptation to new environments. Medicine, as a profession, has made most rapid strides during the last fifty years, and we must keep pace with this continuous rapid progress; failure to do so spells regression.

It is well known that any medical group which is deprived of all the stimulating advantages found in the large medical centers becomes static. Any medical group that is deprived of the advantages of a continuous post-graduate medical education is no special asset to any community.

Modern educators have come to the realization that higher public education is a failure unless it is a continuous process. A tremendous emphasis is placed on the importance of adult education in every community. These supposed modern views were shared by Plato in the fifth century B. C. He believed that education is to continue throughout life, and in that sense he was probably one of the early advocates of modern adult education. Today we cannot accept literally the teachings of Ecclesiastes, that "in much wisdome is much grief, and he that increaseth knowledge increaseth sorrow".

Modern medical education must of necessity be an intensive and continuous process; and because of these rapid advancements, one will find that, unless he participates in this continuous process, much of the progress will have passed him by. We realize that this task of continuous education is rather a difficult one for the general practitioner; but in order to keep pace with medical progress, and to give the people of the community the best that modern medicine can offer, it must be done. We must regretfully admit that, if post-graduate instruction were left entirely to the choice and discretion of some physicians, they would become absolutely static in their knowledge shortly after their graduation. Osler very wisely states that "the killing vice of the young doctor is intellectual laziness. He may have

worked hard in college, but the years of probation have been his ruin."

Fortunately, most physicians are deeply interested in their profession. They are constantly in search of new knowledge, adding and storing away, in their mental storehouse, information and experience gathered from many sources, either at the bed-side, the laboratory, the hospital, or through current literature and medical meetings. But not all physicians are endowed with that gift which impels one to seek information, even if it requires many sacrifices. To some it must be brought and presented in a simple and interesting manner. To those a medical organization such as this offers an excellent opportunity to gain much useful information.

The specialist, because of his position in the community and among his colleagues, must keep pace with the progress made in his particular field. He is constantly scrutinized by his fellow specialists and general practitioners. This does not hold true of the general practitioner whose position among his patients is rather a unique one, since a great deal of his success depends upon his personality and devotion to his patients. Very often a practitioner of mediocre knowledge may be very successful; but if he neglects to attend meetings or read current literature, he will find himself, many years after his graduation, knowing less than when he started.

SECTIONALISM, OR CHAUVINISM IN MEDICINE

Every modern hospital today has its own clinical society where scientific meetings are held. These meetings are very stimulating and conducive to the better practice of medicine. There is no doubt that they serve a very useful purpose in every hospital.

In addition there are in this, as in every other city, several small medical groups or societies, or clubs, as they are called, which are organized presumably for scientific purposes, but in which the social element probably plays a large part. It is only natural that some of these groups, in order to justify their existence, must attribute to themselves some special qualities which, in some instances, amounts to a sense of superiority. This creates sectional differences and a spirit of aloofness. May I again quote Dr. Osler on this point: "Perhaps no sin so easily besets us as a sense of self-satisfied superiority to others."

Provincialism, sectionalism, and chauvinism, as you wish to call it, has no place in medicine. These so-called chauvinistic attitudes, which may be national or local, are purely a condition of the mind, and are frequently disguised under the so-called group-pride or group-ambition.

I think it was Spinoza who said that "the two great banes of humanity are self-conceit, and the laziness coming from self-conceit".

It was Thomas Browne in his book, Religio Medici, who so beautifully expressed the common scientific and humane spirit which should prevail among the medical professions: "I feel not in myself those common antipathies that I can discover in others; those national repugnances do not touch me, nor do I behold with prejudice the French, Italian, Spaniard, or Dutch. I am no plant that will not prosper out of a garden; all places, all airs make unto me one country. I am in England everywhere, and under any meridian."

MUTUAL UNDERSTANDINGS AMONG PHYSICIANS

It is essential for the morale of the profession to instill a mutual understanding and respect through its association between groups of physicians. When these groups are brought together and given an opportunity to exchange their clinical experiences through frequent scientific meetings and social contacts, some of the social barriers between individuals and groups are removed, and a much higher regard for each other is developed. Our Academy has rendered a splendid service in this respect.

There is some satisfaction in the thought that our Academy was able to maintain itself, in a modest way, by our membership dues. Occasionally we have received small contributions through the generosity of our own members, particularly from the members of the Board of Trustees and the Council, for which we are very grateful. Our Librarian's salary was, until four years ago, paid by the city, but this support was withdrawn from us with the advent of the years of depression.

Recently we appealed to the Library Com-

mission and the City Officials, pointing out to them the necessity of maintaining a medical library and the need for its expansion. We asked that our Librarian's salary be restored. Our request was granted.

PUBLIC SUPPORT

At this point, the question presents itself: Do we have a moral right to ask for public support?

What does the public expect to receive from the medical societies? It looks to the medical profession, through their scientific societies, for information and guidance. The knowledge which the physician gains from being affiliated with such an institution as the Academy, is not stored away within himself as a cultural accomplishment for purely personal enjoyment, as may be the case with some other cultural branches of education. On the contrary, it is given cheerfully and unstintingly to the public in terms of more efficient medical service. There is this distinction between the Academy and other organizations which are established for the purpose of advancing the interests of a collective body of men engaged either in industry, or commerce, or even in certain artistic pursuits. The advantages derived from these so-called utilitarian organizations are practically limited to those interested in that particular form of endeavor. This is not the case of medical scientific organizations. All the advantages derived from membership in such organizations are definitely shared by the public. One must not think of the Academy as an institution that is benefiting the physician only. It must be considered on a par with other educational institutions which are established for the purpose of disseminating specialized and higher learning.

We are dealing with the most fundamental human activity, the prevention of disease, the protection of the health of the community, and the preservation of life. The chief reason for our existence and the purpose of all of our activities is to bring to our community, through the local profession, the latest medical discoveries and the most modern methods of medical practice.

In the last analysis, the public gains as much from such an institution as the doctor; and therefore we are an asset to the community and have a right to expect public support if the need should arise.

POPULAR LECTURES

In this connection, I wish to mention the service that the Academy has rendered to the public during the last two years, through a course of lectures to the laity, given under the auspices of the Committee on Medical Education. We have received many favorable comments, and the hope and wish was expressed to your President that we continue with this program. The public is evidently eager for medical information which emanates from authoritative sources. We do hope that the Academy will be in a position to continue these lectures.

WELFARE PROBLEMS

May I venture on another suggestion?

With our present complex system of social life and the general trend toward more complete social organization, it is almost impossible, and certainly not practical, for one group to assume an attitude of aloofness to the many social and economic problems affecting our lives. I believe that a physician, whether his practice is among the rich or poor, should be familiar with many of these problems. One wonders, therefore, whether it would not be practical for the Academy of Medicine to present occasionally some talks dealing with social and economic questions.

Of the three professions, ministry, social service, and medicine, the physician should be in the front ranks of those whose interest in social betterment is an all absorbing question. It is conceded that it is not easy for most of us, who are busily occupied with our daily tasks, to devote much time to other activities; but there are certain problems in every community which, because of their particular concern to the welfare of the individual and his family, should interest the doctor. The life of the laboring man should certainly be of interest to the physician, because there are many ramifications in the worker's life which are closely related to his well-being and that of his fam-

ily. Such questions as child labor, old-age pension, unemployment insurance, and proper housing, are problems of social importance with which the doctor should be familiar and take an active part in their solution.

This thought is brought to you because of a feeling that a better mutual understanding can be brought about between the physician and the public,—and by that I mean that portion of the public which we are accustomed to call the underprivileged,—if we show them that we are willing to share and discuss their problems with them, instead of ignoring them.

If I have digressed from the subject of my paper, and have unduly imposed upon your time, it is because of my anxiety not to omit any of the thoughts that came to my mind which I believe belong within the domain of this, my retiring address as your President.

31 Lincoln Park

CANCER CONTROL

AN ORGANIZED PLAN FOR CO-ORDINATED ACTION IN A GENERAL HOSPITAL

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Read before the Union County Medical Society February 10, 1937

The campaigns against cancer by the American College of Surgeons, American Medical Association, and that of the American Society for the Control of Cancer are now being seriously considered by our State Medical Society. As a result, the State Committee has formulated a general plan of attack on cancer; and upon this basic plan the various counties have been directed by the State Chairman to put in operation methods of cancer control adapted to their own territories.

Union County, like many others in the United States, is not affiliated with a medical school, and is furthermore devoid of a specific tumor control organization. Therefore, it is obvious that we must start from the basic fundamentals in matters appertaining to oncology. These consist in:

1. The promotion of coöperation of physicians, dentists, specialists and hospitals in cancer control.

2. To provide facilities for the diagnosis and treatment which shall be available to every physician in Union County.

THE PHYSICIAN AND DENTIST

It seems to me that the first essential is to facilitate, for the dentist and the general practitioner, the early diagnosis of cancer. A dentist is in position to observe suspicious lesions and actual tumors of the mouth perhaps more often than the physician. While it is true that some dentists do this, nevertheless many of the dental profession so strictly adhere to the biology and mechanics of the teeth alone, that they are prone to overlook small tumors of the oral cavity. A special effort should be made by the dental surgeon and specialists in this field to impress upon the average dentist the clinical features and means of early tumor diagnosis, and to stress the danger of ill-fitting dentures, and sharp-edged teeth in cancer causation.

To the physician also, the early diagnosis of malignancy entails appreciation of the early symptoms and signs of cancer. This is best accomplished by a *tumor clinic,* and *tumor clinical conferences* in which a large number of patients thus afflicted can be demonstrated to him.

At this point it is opportune to say that so far there is no test in the field of clinical pathology which can give a serological diagnosis of malignancy, such as, for example, the Wassermann reaction in syphilis diagnosis. Several biological tests are now being tried, but their specificity, unlike that of the Wassermann reaction, has not as yet been sufficiently demonstrated to accept them unqualifiedly in the detection of cancer. The timely diagnosis of accessible malignancy so far rests with the

biopsy; and when feasible, this is, in fact, the final proof of all suspicious lesions and fully established tumors.

THE BIOPSY

It should be more generally appreciated that a great number of cancers are accessible. These are cancers of the skin, lip, tongue, gums, buccal mucous membranes, roof of the mouth, tonsils, naso-pharynx, nose, antra, pharynx, larynx, breast, rectum, lower colon, vulva, cervix, body of the uterus, bone, and many others. With the aid of instruments, even more remote ones can be reached, such as bronchogenic, esophageal, and sigmoidal cancers. Therefore, the histological proof is generally within reach in a goodly number of suspicious lesions and fully-established tumors.

Any physician can take a biopsy of an accessible lesion, but a more remote one requires the services of a specialist. Those of the rectum and lower colon must be done by the proctologist, or by a physician in possession of proctoscopic knowledge. Biopsies of bronchogenic and esophageal cancers must be done by those versed in bronchoscopy and eosophagoscopy; biopsies of the naso-pharynx and intrinsic and extrinsic larynx must be taken by the nose and throat specialist; those of the prostate and bladder must be removed by the urologist; and so forth through the list.

Martin and Ellis, working at the New York Memorial Hospital, have developed a special method of biopsy which has greatly simplified the identification of deep-seated tumor masses such as those of the breast, bone, and lymph nodes, and even those of the lung parenchyma, by aspiration with an 18-gauge needle. Special training is required both in the method of aspiration and cytological interpretation of aspirated material. This special training, in my opinion, is not difficult, and I have found that the information obtained from the aspiration biopsy is of great value. I know that there are objectors to this method of biopsy, but in my experience, the objections always come from those who neither have nor take the trouble to acquire the knowledge concerning the method.

Much has been written on the pros and cons of biopsy. The objection that the removal of biopsy spreads cancer is more theoretical than real. Any objections by the surgeon should be removed by adherence to the following rules:

1. Biopsy of a doubtful lesion and tumor masses;
2. Diagnosis of the biopsy by a competent pathologist; and
3. The immediate treatment indicated by the diagnosis.

Temporizing after a positive report has been obtained is the real danger of the biopsy. It must be remembered that in doubtful lesions more than one biopsy may be needed. I want to call attention to a frequent mistake in diagnosis, resulting in loss of valuable time, sometimes weeks or months. Often a blood Wassermann is done on a patient with suspicious lesions. A positive report leads the physician to believe the lesion *luetic* rather than *malignant;* and he institutes anti-luetic treatment. I cannot emphasize too strongly that cancer may give a positive Wassermann in the absence of lues; and that a patient may have both syphilis and cancer. Biopsy, then, and not the Wassermann, is the ultimate differential test between syphilis and cancer.

In tumor of the gastro-intestinal tract, exclusive of those that are accessible for a biopsy, the x-ray is invaluable for the early diagnosis.

THE PATHOLOGIST

Having stressed the accessibility and necessity of early biopsy, the next important point is the need for a reliable report by an experienced *pathologist.* I dare say that not all pathologists are good tumor histologists. Therefore, it follows that these men must also be equipped with the proper experience to diagnose tumor sections. Pathologists must realize that oncology is a special and very important field; and that, in order to be proficient in it, they must acquire not only the elementary knowledge of diagnosing malignancy (by the way, even this elementary essential is difficult indeed in some cases), but must also be versed in the histogenesis, grading, and radio sensitivity of tumors. Let me qualify this statement: By histogenesis I mean that it is not sufficient to say sarcoma, or even to use the obsolete terms, round and spindle cell sarcoma. The patholo-

gist must always endeavor to discover whether the sarcoma is lipogenic, neurogenic, myogenic, osteogenic, and so forth. These distinctions are important because lipogenic sarcoma, for instance, may be radio sensitive; while neurogenic sarcoma, on the other hand is very radio resistant.

It is true that individual radio sensitivity cannot be appraised by the microscope alone, since the radio response and the accessibility of the tumor ultimately determine its sensitivity. Nevertheless past experience has shown that at least a rough estimate of sensitivity can be given by the experienced pathologist. Grading tumors may hold the key in deciding for surgery, radiation, or both. The pathologist should also be cognizant of certain biological reactions, as for example, the Ascheim Zondek quantitative reaction in testicular teratomas.

Now, how can we prepare pathologists to give you this information which is the very essence of the attack on cancer? The answer is readily found. Those pathologists who are deficient along any of the lines I have indicated should seek to improve their knowledge in pathological laboratories and cancer centers, where they could have access to a museum of microscopic and gross specimens. The hospitals of Union County possess mountings of gross tumor specimens; and also over 600 microscopic slides which embrace a wide field of tumors, benign and malignant, properly classified as to histogenesis and grading, and reflecting the present knowledge concerning such tumors.

THE ROENTGENOLOGIST, THE SURGEON, AND CLINICAL CONTROL

As in the case of the pathologist, not all roentgenologists are versed in radiology. The radiologist strives to obtain complete cure in cancer; but his efforts in radiotherapy find a larger sphere in *palliation,* by means of which life is prolonged and symptoms are alleviated. In planning radiotherapy, questions of size and number of portals, filtration, dosage penetration, and other important details of technic are considered; but more important than these is the *individual* appraisal and clinical control of the patient. This clinical control should put the surgeon in position to prescribe the amount and kind of radiation needed, thus broadening his concept of attack on cancer. At any rate, he should coördinate his efforts with the radiologist.

Let the surgeon consider the following hypothetical cases: A patient presents himself with an epidermoid cancer, grade II, situated on the anterior lateral aspect of the tongue, but without metastic deposits in the regional lymph nodes. It is realized at once that this patient offers the best chances of complete cure. The surgeon refers the patient to the radiologist for treatment, and under radio-therapeutic attack, the lesion responds to such a degree as to completely disappear. However, a slight thickening may have been left at the site of the original tumor. This small scar may contain cancer cells; and from a pathological point of view, a cancer is equally aggressive whether its structure is composed of a few or many malignant cells. The detection by the surgeon of the residual thickening, and its eradication by him through interstitial radiation, are of vital importance to the patient.

Nor is this sufficient. On the surgeon falls the responsibility of the patient's follow-up, so that recurrence of the lesion be kept under control. Unfortunately, in our community such coördinated work does not exist, thus emphasizing again the need of an *organized tumor clinic* in which both the surgeon and radiologist should put into operation their individual knowledge in a combined effort to efficiently control cancer.

CO-ORDINATIVE MANAGEMENT

The proper treatment of cancer requires the combined efforts of surgeons, radiologists, and pathologists, and is certainly not a one-man job. The question of whether a particular patient should be treated by surgery alone, or by radiation alone, or by both, can be answered adequately only by *group consultation.* Consider, for example, the breast,—a common site for tumors. Advanced breast cancers usually show outspoken physical signs of their true nature, such as nipple retraction, fixation of the mass to the skin or deep structures, or both, and axillary lymph gland deposits, and so forth.

Early breast cancers may only show the tumor in which case the surgeon may be doubtful of the exact nature of the disease. The surgeon will operate to find out; and if he has the facilities, he will call a pathologist to do a quick frozen section for the solution of the problem. If the pathologist is inexperienced, both he and the surgeon may be in error as to the exact nature of the tumor, and the result will be either an unwarranted diagnosis of cancer cure, or an unexpected malignant recurrence. Furthermore, it often happens that a more minute investigation of the resected mass in the laboratory by the pathologist reveals small, but nevertheless metastasized, lymph nodes which were not clinically evident. Since the radical operation has been done, it does not matter, one would think, if such is the case. This is a false assumption, because if axillary deposits are found one way or another, the chance of these being elsewhere in the body cannot be ignored.

The demonstration of metastases in the bone and lung is the work of the *roentgenologist.* Dresser and Pelletrer have shown that the radiographic investigation of distant metastases in the skull, spine, lungs, pelves, and upper femora in breast cancer can be economically accomplished by exposing four films. It is evident, therefore, the the management of a breast tumor is more complex than is fully realized. It requires the coördination of a surgeon, roentgenologist, and pathologist for the welfare of the patient and to safeguard the reputation of the surgeon. Undoubtedly, such investigation of breast cancer is being done, but there is need for a more extensive coördination of the efforts of all the specialists.

ORGANIZATION FOR SPECIFIC TUMOR CLINIC

Usually in any given county there will be found more than one hospital. A properly organized and conducted tumor clinic should be established in at least one of these hospitals. The clinic should have adequate radio therapeutic equipment, including low, medium, and high voltage x-ray machines, and a minimum of 150 mgs. of radium. The tumor clinic should be organized and directed by a specialist in oncology,—that is, a physician who has had special training for three or more years in a tumor hospital such as the Memorial Hospital of New York City. In addition to the Director, there should be recruited from the hospital staff a *clinical consultation group, a radiologist,* and a *pathologist.*

The clinic should be a source of *education* to the general practitioner by means of clinical conferences and other methods. The consultation staff of the clinic should render expert service in the diagnosis and treatment of patients sent by any physician in the county.

The patient should always be sent back to the referring physician with the diagnosis and recommendations for treatment. The physician is thus given free choice of referring the patient either to the clinic, or the private radiologist, for treatment.

The tumor clinic should serve as a *tumor registry* where physicians in the county ought to file the name of the patient, together with clinical data and the histological section whenever available. This information ought to come from private physicians and hospitals. Thus the tumor registry would serve two purposes:

1. The number of tumor patients in the county would be known.
2. The submitted sections would build up a slide museum of tumor histology.

If more than one tumor clinic be established in the other hospitals, then only one of these should serve as a tumor registry.

A tumor clinic should be affiliated by special arrangements with the pathological departments of the hospital. By special arrangement, I mean separate provision for oncology. In the pathological department of the hospital, a museum of gross tumor specimens, and a large collection of tumor slides' histology should be established, indicating, as far as possible, the grading, the histogenesis, and the group radio sensitivity information for the instruction of clinicians and student pathologists.

The tumor clinic should be affiliated by special arrangement with the hospital roentgenological department, which should include a *museum of x-ray films* emphasizing bone, gastrointestinal and lung tumors, for the instruction of clinicians and student roentgenologists.

A biopsy service should be established in the pathological department. Here outfits with

printed instructions and fixative solutions should be prepared and stored for distribution to physicians. A similar procedure has already been carried out for syphilis in the Wassermann outfits.

A special personnel and equipment should be established for paraffin sectioning of biopsy material submitted by the physician for examination and diagnosis. If he wishes, the physician may have the biopsy examined elsewhere; but in any event, this department should be available for any histological opinion on microscopic sections which may be submitted by the physicians or other pathologists. The biopsy service should render this work free of charge to those who are unable to pay.

Of course, financial support must be had to establish and maintain this service. The expenditure for equipment, including special diagnostic instruments, is estimated at about $30,000. This fund may be furnished by the hospital in question, or by the county, or solicited from a benefactor as a memorial. This amount would cover only establishment. It is thought that a special fund for maintenance may not be necessary as the clinic would be self-supporting.

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PLASTIC REPAIR AN AID IN THERAPEUTIC NASAL SURGERY

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The operation most generally accepted and used to relieve defective nasal breathing is the classic submucous resection. I take it for granted that the most common cause for the physiological failure is a deflected septum. The operation as we know it today is of rather recent development, and has evolved through various technics. As late as 1900 the standard textbooks did not mention it. Until 1904, when Killian first described the submucous resection, the operations employed were: (1) A punch, which consisted simply of a modification of an ordinary shoe punch; (2) a crusher, which mechanically crushed the spur of the septum; (3) later on, Bosworth used a saw, sawing right through the mucous membrane and the cartilages; (4) drills were also used.

These operations, of course, left considerable deformities intranasally. The delicate and thorough surgical procedure of the submucous



Case 1.—Incomplete relief from submucous resection done because of thick, rounded triangular cartilages impinging on nasal opening



Case 2.—Insufficient relief from submucous operation because of long redundant nasal tip



Case 3.—Combination of the elements of cases 1 and 2



Case 4.—Long, narrow, scoliotic nose in which plastic and submucous resections are both indicated

resection, as we do it now, has done a great deal to place this operation among the most vital and necessary procedures in therapeutic nasal and aural treatment. It is no longer a brutal, crude, and deforming operation; and it is a very necessary one. Performing it causes no loss of any vital tissues. The mucosa is no longer mutilated, and there is no further necessity for fear on the part of the patient or hesitation on the part of the surgeon.

Very often, however, in spite of a perfect operation, the patient will still complain of difficulty in nasal breathing. This incomplete result may be due to another factor which has been overlooked. It may happen that the function of the nose has been affected by external or internal nasal deformities, which are frequently overlooked, or are not considered of sufficient importance to be corrected at the time of the operation. When we have deformities such as narrow nostrils; a scoliotic nose, in which the base and the tip are at different angles; a long, narrow nose; a thick columella; thickened triangular cartilages with adhesions; a redundant tip; or excessive soft tissue. performing the submucous resection without correcting these deformities is very often the cause of an unsatisfactory result in relieving the patient of his symptoms.

Since the World War a great impetus has been given to the development of rhinoplasty, or the plastic repair of nasal derformities. After the war the purpose of a great many of these operations was, of course, cosmetic. However, the results obtained in combination with a good submucous resection, were often beneficial to health as well as an improvement in the patient's appearance.

I have found that in the cases where I performed a submucous resection with insufficient relief of symptoms, I was able to get a much more satisfactory result when I corrected the nasal deformities. The technic of these operations has been so well standardized lately that it is my opinion that where we are employing the submucous resection for defective breathing, the deformities of the nose should be corrected at the same time. I have several cases here which I wish to use as illustrations.

Case 1.—The first case is that of a female of forty-three who gave a history of having had a submucous resection performed several years ago by a well-known rhinologist. The operation had been ably performed, but her nasal breathing was still not sufficiently improved. In my opinion, the operation had not been completed because this particular patient had thickened, rounded, triangular cartilages which impinged upon her nostrils and impeded her breathing. It was only after the triangular cartilages were entirely removed and the adhesions broken up that, as a reuslt of increased breathing space, the patient was physiologically improved.

Case 2.—The second case is that of a young female who had had a submucous resection performed by me several years ago, but who had a large redundant tip which came down in such a manner as to shut off the entrance of air into her nares. She returned some time later, still complaining of defective breathing. In this case it was necessary to lift the tip, shorten the nose, and bring up the nares. The operation of removing the encumbrances gave the patient increased breathing space, which the submucous alone had not done.

Case 3.—The third case is that of a male of twenty-five who had a long narrow nose, deviated septum, and very narrow nostrils. In this case his nose was shortened and the nares widened when the submucous was performed. I feel certain that to have done only a submucous resection in this case would not have given the patient sufficient relief from his breathing difficulties.

Another common nasal deformity is the sublaxated columnar cartilage. This deformity is present in a great many traumatic cases, and usually occludes the nasal passage. It should always be corrected when a submucous resection is performed.

We cannot overlook the fact that there is an added risk of general infection, but with proper technic and training and extra precaution the danger is greatly minimized, and the risk of infection should be no greater than it is following an ordinary submucous operation.

In cases of nasal deformities and defective breathing the surgeon should pursue the course which would give the patient the best functional result, even if cosmetic surgery has to be resorted to.

In conclusion, it is my contention that in cases of nasal deformity which interfere with breathing, a submucous operation is not sufficient to give the patient the promised relief. We should take cognizance of the fact that the correction of the deformities of the nose is absolutely essential in making this operation complete.

THE PRACTICAL RESULTS OF MODERN CANCER RESEARCH

THE SECOND HARRISON STANFORD MARTLAND LECTURE OF THE ESSEX COUNTY ANATOMICAL AND PATHOLOGICAL SOCIETY

By James Ewing, M.D.

Director, Memorial Hospital, New York City

Delivered before the Academy of Medicine of Northern New Jersey, Newark, N. J., December 3, 1936.

I appreciate highly the honor of the invitation to give the Harrison S. Martland Lecture for 1936. The establishment of this lectureship gives great satisfaction to Dr. Martland's many friends, and especially to his colleagues in pathology. It stands as a well-merited tribute to a physician who many years ago, by clear discernment, created opportunities in a neglected field, and by indefatigable industry and high intelligence, placed general pathological service and legal medicine in the City of Newark on a high plane. The scope of his activities and influence has extended far beyond New Jersey, and especially into New York City, where his record of service has been of outstanding value, so that we claim him as a representative of New York medicine, while acknowledging our debt to New Jersey. Dr. Martland's successes have been accomplished without the aid of organized or university medicine, and possibly the early lack of such connections and the resulting freedom of action account in part for his originality, and the unrestrained vigor of his personality. As an old friend and colleague, I welcome this opportunity to express my obligation to him for constant coöperation and inspiration in our chosen field of pathology. In establishing this lectureship, the medical profession of New Jersey has honored itself, and received the approval of the medical profession of the country.

In considering a topic for this lecture, I was inclined to indulge myself in a discussion of some fundamental subject in general pathology. I proposed to give a theoretical discussion of catarrhal inflammation. But owing to the varied interests of Dr. Martland's wide circle of friends, and the composition of this audience, I have been urged to invite your attention to some topic in the field of cancer, with which I have long been identified. I propose, therefore, to briefly review the main events in the history of cancer research and cancer control during the recent modern era, and attempt to evaluate these results, and to draw some conclusions regarding the probable trend of the future. By this retrospect, we may wisely direct our own efforts.

IMMUNITY

The modern era of cancer research began about 1902 with the discovery by Jensen and Loeb of the transplantability of lower animal tumors. In the course of a decade, work with such tumors disclosed the very narrow range of nutrition of tumor cells, the influence of change of diet, and of many minor disturbances in the blood of the tumor host. It showed that the host tissues possess a peculiar type of resistance to implantation of tumor fragments, by which the tissues exerted a sort of organized resistance of the tumor. The general absence of any type of chemical immune substance to the tumor, comparable to bactericidal agents, was demonstrated; but no uniform behavior of different tumors, in their immunity relations, has been observed.

Lumsden claims to secure an immune serum by injections of tumor material in rabbits, but the immune properties are very delicate and evanescent, and many observers have failed to confirm his results. The Brown-Pearce rabbit carcinoma frequently leaves the animals immune after spontaneous regression of a tumor produced by inoculation into the skin. Besredka claims to have secured the same results with mouse sarcomas, but others have failed to duplicate his results. It thus appears that different tumors differ in their immunity relations. Injections of active tumor material seem to increase the growth rate of existing tumors, while there is some evidence that injections of autolyzed tumor material confer some resistance. In man, there is little clinical indication

that any substantial form of immunity ever arises in the course of tumor growth. Observations on human subjects indicate that successive occurrence of major forms of cancer is by no means infrequent. Hartman found twenty-seven such cases in a limited material, and Regaud reports that about three per cent of his cured cases of uterine cancer later developed another form of cancer. According to Zilberszac (Le Cancer, 1936), American statistics show about 3.9 per cent of successive malignant tumors in autopsied cases.

HEREDITY

Tumor transplantation opened the important field of the experimental study of heredity, by which it has been shown that in inbred strains of animals, heredity plays a predominant part in the incidence of, and susceptibility to cancer. These studies served to strengthen the belief that in human beings also, heredity is an important factor in the incidence of some tumors, but they did not equal in importance, or in any way replace the heredity studies of clinicians, on the influence of heredity as observed in the human subject. The studies of Davenport, Wassink, and Wainwright, on the hereditary influence in various human tumors are far more decisive on the question. They show that some human tumors are notably influenced by heredity, while others are not.

TISSUE CULTURE

Tissue culture in vitro has been very extensively pursued in a great many laboratories. It revealed in a sensational manner the capacity of cancer cells for independent existence, and showed that the malignant cell is a more or less immutable and radically altered cell type, the malignant growth qualities persisting in independent strains, and unchangeable over many generations. Its original promise to reveal the secret of the cancer cell has not been realized. Tissue culture has been of great value in determining the reaction of cancer cells to changes in nutrient substances, to radiation, and other physical and chemical agents. It has been of more value in experimental embryology and morphology, and in virus studies, than in cancer, in which fields it has provided an entirely new and fruitful method of investigation. Carrel thought he had transformed chicken fibroblasts in tissue culture into sarcoma cells, by inoculating the culture with the chicken sarcoma virus; but when he injected the supposed sarcoma cells of the culture he also injected the virus. One observer, de Ligneris, has recently reported the transformation of normal cells into malignant cells, by inoculating the cultures with benzpyrene, and subculturing for several generations.

CHEMICAL COMPOSITION

Chemical studies have shown that the composition of tumor tissue does not differ in important respects from normal tissues. The ferments of cancer tissue differ in quantity, but not in kind, from those of normal tissue. A vast amount of chemical investigation has been expended in the effort to discover a special chemical or serum test for cancer. More than a score of these tests are now claiming recognition, but the recent comprehensive reviews by Hortega and by Rondini, reported at the Brussels Congress, 1936, have shown that none of them is of definite practical value. The situation in this field is reflected by the suggestion that, if three or four of these elaborate tests could be combined, the clinician might feel reasonably assured of the presence or absence of advanced cancer.

Much labor has been expended by Waterman, Reding and Sluys, in the effort to demonstrate a chemical change in the blood, an alkalosis, as an indication of a predisposition to cancer, but these claims have not received any recognition and are probably misconceived.

The most important contribution to the chemistry of cancer is that of Warburg, who showed that the metabolism of cancer cells is of fermentative type and not oxidative. The ability of the cancer cell to appropriate oxygen is injured and deficient. The various elaborate attempts to treat cancer by supplying oxygen have failed, and probably for this reason. Yet today the most cleverly exploited constitutional remedy for cancer is said to be based on the supply of oxygen in the form of peroxidases.

In this country, and in Brazil, oxygen therapy of cancer has been employed on an elaborate scale, producing only the peculiar toxic effects of oxygen, but no relief of the cancer. While a fermentative metabolism is not limited to cancer cells, and does not reveal the secret of malignancy, it carried us further into the secrets of the cancer cell than any other contribution from chemistry, and the disposition to depreciate Warburg's contribution is hardly justified.

CANCERGENIC CELL-FREE AGENTS

Specific growth-stimulating substances in cancer have been sought in several directions. Sulphydral compounds, and glutathione are present in many actively growing plant and animal tissues, and in cancer tissue, but they stimulate normal and not malignant growth. Some years ago, Gurwitz announced that all actively growing yeast cultures, placed in quartz glass tubes, started up the growth of stale yeast cultures, through the action of radiant energy, mitogenic rays, falling in the range of 2400 Angstrom units. He conceived that the presence of many mitotic cancer cells stimulated in increasing degree the growth of neighboring cells, thus establishing a vicious circle. Mitogenic rays have been the subject of many elaborate investigations, with inconclusive results. The last report of an American Commission on this subject left the matter rather sub judice, but did not entirely dispose of mitogenic rays.

THE VIRUS THEORY

The old theory of the parasitic origin of cancer failed to survive the accumulating evidence of the transplantability of lower animal tumors, the artificial production of cancer by x-rays, and the observations on tissue cultures, but it still survives in modified form, in the virus theory. The main evidence comes from the group of fowl sarcomas, which Rous showed could be transmitted by a cell free filtrate. A vast amount of labor has been expended on this subject, and opinions remained divided, Rous and Andrewes and Gye holding that the filterable agent is a virus, while most other observers believe that it is a chemical substance derived from the cells. Murphy and his associates have furnished practically conclusive evidence in favor of the chemical nature of the substance. Stanley has shown that the virus of the mosaic disease of the tobacco plant is a crystallizable chemical substance which possesses similar properties with those demonstrated in the fowl sarcoma virus. The final solution of this whole problem of the sarcoma virus must await further knowledge of the nature of viruses in general.

Shope discovered a papilloma of the skin of wild rabbits, which is transmissible by a filterable agent, probably a virus. Rous found that this papilloma is more active in domestic rabbits, and often becomes bulky, fissured, infected, and eventually in some instances, becomes transformed into a type of squamous carcinoma with occasional metastases. He has thus demonstrated that a virus is capable of inducing a process which may run into cancer. When inoculated into the skin, previously treated with benzpyrene, the papillomas grow more rapidly, and the malignant tendency is enhanced. Exactly similar events appear to occur in the course of syphilitic condylomas, and the question remains, what part in the malignant transformation is played by the virus, and what part by infection and traumatism. The infectious nature of common warts was demonstrated in 1906 by Hahn, who successfully inoculated warts on the back of his gardener's hand. However, the observations of Rous suggest that some of the common papillomas of man may be due to viruses, and that in the causation of many tumors, multiple factors may be at work. Murphy and his associates have found that extracts of many tissues contain tumor-activating agents, while others, especially placenta, yield inhibiting agents; and he has formulated the doctrine that tumor growth may be due to maladjustments between the activating and the inhibiting agents normally present in the tissues.

CHEMICAL CANCERIGENIC AGENTS

That tissue cells produce chemical substances capable of exerting both growth-stimulating effects and alterations in cell type, has been shown by Spemann. He found that when ex-

tracts of embryonal neural tissues were injected into the dermal epithelium of the embryo, the epithelium changed its character and produced neural tissue. He thus developed the doctrine of embryogenic organizers and inducers, which opens up an entirely new and fundamental field in cell pathology which may have important bearing on many of the phenomena of tumor growth.

In 1900 we used to boast that no one had ever produced a malignant tumor experimentally. Today there are many methods of inducing experimental malignant tumors. The first of these appeared when epidermoid cancer began to appear in many workers who exposed their hands to soft x-rays. Several forms of malignant tumors, carcinoma and sarcoma, have been produced by x-rays.

The tar cancers have been the subject of a vast amount of study, culminating in the discovery, by Kennaway and Cook, of very active cancerigenic agents in the high distillation products of coal tar. These compounds belong in the series of cyclic aromatic compounds, and the most active is benzpyrene. By the decomposition of bile acids they secured methyl cholanthrene, which is the most active cancerigenic agent known. These compounds are now used extensively in the artificial production of cancer and sarcoma. It next appeared that the cancerigenic cyclic compounds are closely related to certain hormones occurring in the body, especially oestrin, and to vitamin A; and the basis was laid for the theory that some cancers, naturally occurring in the body, result from the action of bile acid derivatives, cholesterol and hormones. Various other chemical agents have been successfully employed in the production of cancer.

Thus, a glance over the field of modern cancer research shows that our fundamental knowledge of cancer has expanded enormously, covering transplantability, conditions of nutrition, heredity, tissue culture, physical properties, immunity and resistance, chemical composition and metabolism, cancerigenic cell-free agents, viruses, and specific cancer-producing chemicals. It may be said that the great bulk of our knowledge of the general biology and nature of cancer has been contributed in this modern era of the twentieth century; and yet the so-called ultimate cause of cancer has not been revealed.

CLINICAL AND PATHOLOGICAL RESEARCH

Along with fundamental laboratory research, clinical studies on cancer in the human subject has been conducted on a broad scale by many surgeons, radiologists, and pathologists, with results of the highest importance.

When I was a medical student, we were taught to believe that cancer was cancer, and sarcoma was sarcoma, and that was about all there was to the subject. We were shown two or three microscopic slides of each of three or four types of tumors, and a few gross specimens. With the increasing interest aroused by the discovery of the transplantability of lower animal tumors, new interest developed in human tumors. The older pathologists had rather fully described the gross anatomy and usual structure of the main varieties of malignant tumors, and a good deal was known about comparative malignancy; but histogenetic diagnosis was not highly developed, and the finer classification of the many varieties of tumors in the organs was hardly attempted.

GRADE OF MALIGNANCY

There can be no hesitation in attributing mainly to the advent of radiation in diagnosis and treatment, the rapid growth in the refined pathological diagnosis of tumors in the past twenty-five years. Radiation treatment being available, it became possible to make practical use of the refinements of diagnosis and prognosis. Grades of malignancy were long recognized in certain types of tumors. In 1820 Warren emphasized the benign character of giant cell tumors of bone; and in 1860 Nelaton pointed out that the presence of many giant cells assured a benign character in such tumors, while with the increasing age of the patient, and diminishing proportions of giant cells the prognosis became less favorable. Today, we estimate the grade of malignancy in all tumors, following the scheme of Broders, or we attempt even more accurate prognoses, by calcu-

lating the clinical index of malignancy as proposed by Lee, which includes consideration not only of histological signs but of all the clinical features of the disease. Tumor pathologists now recognize many histological pictures as indicating either a fatal prognosis, or a comparatively benign course. Thus the small tubular duct carcinomas of the breast are nearly always fatal; while a remarkably favorable outcome of certain breast carcinomas, composed of large sheets of clear cells, is described by Delbet as giving a remarkably favorable prognosis even in advanced stages. Chorioma testis is nearly always fatal, but many seminomas are cured, in the stage of metastases, by radiation. Throughout the entire range of tumors, such individualistic estimates of prognosis may often be made, with great benefit to the patient.

Such considerations have led to extensive subdivisions of tumor groups, formerly regarded as homogeneous. Thus, the group of epidermoid carcinomas must be subdivided into:

A. Basal cell carcinoma, radio-sensitive, and not metastasizing;

B. Adenocystic basal cell carcinoma, radio-sensitive but widely metastasizing;

C. Squamous carcinoma, radio-resistant.

D. Transitional cell carcinoma, radio-sensitive and metastasizing;

E. Lymphoepithelioma, very radio-sensitive and metastasizing early and widely;

F. Spindle cell carcinoma, very radio-resistant, and

G. Pigmented epithelioma, not related to melanoma.

The estimate of radio-sensitivity began early in the progress of radiation therapy, and today, there is an extensive body of data relating to this complex subject. Very wide variations in radio-sensitivity are observed, and must be attributed to the structure and cellular composition and origin of the tumor, to the character of the tumor bed, and to the general condition of the patient. Upon such data, the entire plan of radiation therapy must be designed.

RADIATION THERAPY

The discovery of radium and x-rays was a contribution from pure physical science, but the application of these agents in the treatment of cancer was developed solely by the efforts of physicians and radiologists, directed to the alleviation of disease in the human subject. It has depended heavily on the ingenuity of electrical engineers, and has profited greatly by many experimental studies, but it has progressed mainly through observations at the bedside. Radiation therapy has revolutionized the treatment, and greatly improved the outlook of many major forms of cancer, and stands today as the outstanding contribution to curative medicine of the twentieth century.

With the introduction of high voltage x-ray machines, divided dose technic, heavier filtration, and limited portals, many radio-resistant tumors are falling within the range of curability by radiation. Equally important with the progress of radiation therapy has been the development of radiological diagnosis, which has become a very extensive branch of diagnostic medicine. It furnishes the surgeon and the radiologist with early and curable stages of malignant tumors, and it has provided the pathologist with new material for the study of the causation, and pathogenesis of many tumors which previously were imperfectly understood. At the same time, a great many new procedures and instruments have been brought into the field of tumor diagnosis, such as the cystoscope, bronchoscope, gastroscope, etc., all of which have improved substantially the scope of early diagnosis and the outlook for the cancer patient.

STUDIES IN TUMOR PATHOLOGY

In the pathological laboratory, many new methods of study of tumors have been introduced which have added to our knowledge of the nature and significance of tumor growth, and also influenced their treatment. We regard the method of aspiration diagnosis, in competent hands, as a definite step in advance, of great value to many patients. There is now a well-defined department of oncologic physiology which is being developed in the tumor

clinic, and which furnishes information of fundamental and practical importance. We have long known that metastatic thyroid tumors produced thyroxin. Tumors of the parathyroid are responsible for many cases of osteitis fibrosa cystica and giant cell tumors of bone; and their removal has been followed by spontaneous regression of these lesions. The estimation of phosphatase in blood and urine is of value in the diagnosis of many diseases of bone. Bence Jones proteinuria is pathognomonic of plasma cell myeloma. Certain tumors of the adrenal cortex produce precocious masculinization, which disappears after removal of the tumor. The classification of the whole group of ovarian tumors is now being remodeled on the basis of their physiological functions. Prolan A appears in the urine of teratoma testis, and its assay permits one to follow the course of radiation therapy of many of these tumors. An extensive field of research is now rapidly growing up, possibly too rapidly, about the hormone relations of many tumors, the results of which must eventually be checked by observations on the human subject. Vitamin deficiency is making itself felt as a probable factor of importance in the pathogenesis of certain tumors.

All of these lines of investigation, centering upon the cancer patient, have largely transformed the complexion of work in the pathological laboratory and clinical departments of the cancer hospital, and all of them, while fundamentally important, tell directly to the advantage of the cancer patient. So broad is the field now confronting the pathologist in the study of human tumors, that there is little wonder that some pathologists are deliberately proposing to specialize as tumor pathologists.

TUMOR SURGERY

This same necessity of great specialization extends inevitably into the field of cancer surgery, which has been greatly modified, complicated, and expanded by the new developments. It begins to appear that the surgeon who wishes to handle cancer cases to the best advantage must be a surgeon, a radiologist, and a good deal of a tumor pathologist. We are thus forced to the conclusion that the tumor service in general hospitals should be highly organized, and that a certain number of special cancer hospitals should be provided.

ORGANIZATION FOR CANCER CONTROL

The foregoing sketch of the contributions of fundamental cancer research on the one hand, and of clinical research on the human patient on the other hand, clearly reveals the fact that the benefits to the cancer patient secured during the past thirty years have come almost exclusively from the latter pursuits. There are abundant indications that in the next period of years history will repeat itself. The direction of effort in the immediate future should therefore be toward the development of more trained clinicians, surgeons, radiologists, and pathologists, concerning themselves with the problems of cancer as they present themselves in the cancer patient.

Yet when any medical organization secures a substantial fund for cancer study, there is a strong tendency as the first step, to employ a chemist or biologist, who knows little or nothing about cancer, and to embark on some fundamental research regarding the ultimate nature of the cancer process. Meantime, it often appears that the cancer patients in that locality are not receiving the best possible attention. It appears to the writer that the first step in the organization of cancer control in any community should be the provision of first-class clinical service, under cover of which one may pursue at his leisure, and without reproach, any number of interesting fundamental researches.

THE PHYSICIAN AND HIS PRESCRIPTIONS

PHARMACEUTICAL ARTICLE NUMBER TWO

By Chester I. Ulmer, M.D., Gibbstown, N. J.
Chairman, Committee on Pharmaceutical Problems, The Medical Society of New Jersey
and
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Editor, New Jersey Journal of Pharmacy

For some time it has been observed that many physicians have become indifferent about prescription writing, and have developed a tendency to prescribe certain proprietary products in preference to offical preparations. Some observers have said that this diminished use of official preparations is the result of the lessened time and effort in teaching therapeutics in medical schools of the country, and that the young physician gets a significant part of his training in therapeutics from the advertising material of the drug manufacturers. Perhaps such criticism of medical curricula has been justified in certain instances, but at present there is a very definite trend toward the proper emphasis on therapeutics in the medical schools. This is being accomplished by a better understanding and coöperation between the clinical and pharmacological departments.

COST OF PRESCRIPTIONS

In these days when the subject of medical economics is so often discussed, the cost of drugs is certainly an important consideration. Since the promotion of official drugs and preparations involves no sales service or advertising overhead, it is obvious that these substances should be and are obtainable at less cost to the patient. This is of considerable advantage to the poorer class of patients, and also to the hospital drug departments supplying the ward or low-wage group of patients. There can be no criticism of this drug-cost reduction, since there is no lowering of efficiency because the therapeutic quality of the drug is always assured by its official rating.

The elegance of certain non-official preparations and the physicians' lack of knowledge of pharmacy in formulating a satisfactory prescription containing other than the single active drug often influences the use of some particular proprietary preparation. There will be special occasions, of course, when a physician will be justified in using other than official preparations, but in most instances he will be abundantly able to satisfy his requirements by selections from the U. S. P., N. F., and N. J. F. formularies.

FLAVORING WITH ADJUVANTS

The physician who prescribes his medication so as to make it look appealing and taste pleasant usually wins the gratitude of his patient. To supply medicines in palatable form is a part of the art of the pharmacist.

In this article the attention of physicians is called to a wide variety of vehicles available for conveying and flavoring official drugs; and the physician's attention is directed to the fact that the modern pharmacist is well qualified to furnish information on the best methods of supplying official drugs which the physician may wish to prescribe.

Dr. Bernard Fantus, Professor of Therapeutics, University of Illinois College of Medicine, and Director of Therapeutics of Cook County Hospital, says:

"There is one maxim about the flavoring of medicines which should be obeyed whenever the flavoring of an odorless medicament is thought desirable, namely, that mild odors not only are more pleasant, but also are relished for a much longer time than are strong odors. Nothing becomes progressively more objectionable than having to endure a strong odor continually or repeatedly. Whenever possible, we should use delicate odors in medication, and avoid an odor so strong that it persistently obtrudes itself. Therefore, unless the disagreeable odor of medicine must be concealed, let us use the delicate flavors of fruits and flowers rather than the heavier odors of woods and barks.

"The delicate fruit flavors, such as raspberry, strawberry, or cherry, are eminently suitable for

medicaments of sour taste. Because of the natural acidulous property of these fruits, the use of them for medicines of a salty or bitter taste is likely to make the victim feel that the fruit syrup has 'spoiled'. Anise, fennel, and cardamom are flavors especially associated in our minds with glycyrrhiza, and children's medication.

"It is only when we must disguise an offensive odor that we should resort to the stronger flavors, such as cinnamon, sassafras, cloves, wintergreen, peppermint, spearmint, and ginger; and when using them, employ them in the smallest quantity necessary to overcome the objectionable odor."

Flavoring medicines and the use of vehicles must, of course, take into consideration the solubility of the drug which the physician desires to prescribe. The medicated waters of the U. S. P. and the N. F., and the syrups of the U. S. P. and the N. F. are satisfactory vehicles for water-soluble drugs. The elixirs of the U. S. P. and the N. F. are available when the drug requires some alcohol for solution.

ELIXIRS

A nationally conducted survey of ten thousand prescriptions, the results of which have been published, proves that the elixirs are very popular adjuvants. Of this class of preparations there are only two in the U. S. P. XI, namely, aromatic or simple elixir, and elixir of licorice. These are used as vehicles, and the elixir of licorice is especially useful in masking a dose of bitter drugs. In the National Formulary the following elixirs are listed:

1. *Aqueous Elixir (Elixir Aquosum),*—prepared to meet the demand for a vehicle of the elixir type but without alcohol. It is colorless and has a pleasant taste.

2. *Red Aromatic Elixir (Elixir Aromaticum Rubrum)*—The N. F. has simply transformed well-known, colorless, aromatic elixir of the U. S. P. into a bright red elixir. From a psychological viewpoint, this is frequently desirable. It contains about 23 per cent alcohol.

3. *Elixir of Bitter Orange (Elixir Aurantii Amari)*—This elixir has a yellow color, and a delightful taste, and is valuable where a high alcoholic content is desired.

4. *Compound Elixir of Cardamom (Elixir Cardamoni Compositum)*—This elixir is colorless and contains about eight per cent alcohol. Its predominant flavor is cardomom.

5. *Compound Elixir of Vanillin (Elixir Vanillini Compositum)* — An amber-colored elixir with a very delightful odor and taste, making it one of the most palatable elixirs of the vehicle group. It contains about eight per cent alcohol.

SYRUPS

Syrups, because of their intense sweetness and heavy body, are particularly useful as vehicles for salty substances. Special attention is called to the following:

1. *Syrup of Acacia (Syrupus Acaciae)*—This is a new addition to the Formulary and has been devised as a specific vehicle and not just as a suspending medium in the old sense of the term. The advantage of acacia lies in the collodial nature of the product which permits dispensing of disagreeable substances and prevents them from coming in contact with the taste buds. This syrup tastes and keeps well. It is flavored with vanilla, and preserved with sodium benzoate. It disguises the sharp taste of urea, often used as a diuretic.

2. *Syrup of Cherry (Syrupus Cerasi)*—This is a new vehicle, and a very valuable one. It is made from the fresh juice of sour cherries and sugar. It has a brilliant red color, and a most pleasing taste. Where you have prescribed syrup of *wild* cherry in the past, try plain syrup of cherry, and the palatability of your prescription will be improved. Patients like changes in the tastes of medicines. Syrup of cherry carries iron medication nicely. This fruit flavor is especially useful with sour substances, and is ideal for such materials as diluted hydrochloric acid or diluted hydriodic acid.

3. *Syrup of Prepared Cacao (Syrupus Cocao Praeparati)*—Chocolate syrup, as it is commonly called, is very thick, creamy, and smooth. Therefore, it is frequently employed as a vehicle for the quinine salts.

4. *Syrup of Cinnamon (Syrupus Cinnamomi)*—A reddish brown syrup with a delightful taste. This new syrup of cinnamon is an ideal vehicle for masking the disagreeable taste of the salicylates. As a rule, salicylates darken in solution on keeping; and therefore a vehicle

such as syrup of cinnamon should be chosen because of its color, to prevent the patient noticing the change.

5. *Aromatic Syrup of Eriodictyon (Syrupus Eriodictyi Aromaticus)*—This syrup has long been used as a vehicle for bitter substances, such as the quinine and strychnine salts. This syrup has a dark, reddish-brown color, and a pleasant characteristic taste.

6. *Syrup of Glycyrrhiza (Syrupus Glycyrrhizae)*—This syrup is particularly recommended for salty substances, such as the chlorides and bromides. Sodium bromide is best disguised by this vehicle, and the unpleasant taste of potassium iodide and ammonium chloride is made less objectionable by the use of syrup of glycyrrhiza. It has a dark brown color, and is flavored with a delightful blend of aromatics.

7. *Syrup of Raspberry (Syrupus Rubi Idaei)*—This is one of the most palatable syrups of the N. F. It has a deep red color, and is particularly useful as a vehicle with acid preparations.

MISSED ABORTION

MATERNAL WELFARE ARTICLE NUMBER TWENTY-ONE

By CARL H. ILL, M.D., F.A.C.S., Newark, N. J.

Missed abortion is a comparatively rare finding in obstetrics; consequently this case is being reported, also its treatment and results.

Mrs. E., aged forty, consulted me on the 13th of February this year. Her past and family history were essentially negative, except for an appendectomy, and at times a systolic murmur at the apex. Her obstetrical history was that of two miscarriages; one at two and one-half and one at three months; both apparently came on spontaneously and caused her no trouble.

At three months she spotted somewhat, and stayed in bed for the best part of a month. She was first examined vaginally one month previously. For the past month she had not felt life and apparently was getting smaller; weight 155 pounds, blood pressure 120/70, and urine negative. Abdominal examination: Uterus was very soft, and felt like a bag of water, and was displaced to the right about five cm. above the umbilicus. Foetal heart was not heard. Vaginal examination confirmed this and no presenting part was felt. A diagnosis of missed abortion was made.

On Monday, February 22nd, she began to have pains and was admitted to the hospital. The uterus was very small, not reaching to the umbilicus. After three hours of moderate pains a dead foetus was expelled with placenta and membranes intact. The membranes were opened and a mumified foetus was disclosed which evidently had been dead for some time. She made an uneventful recovery and was discharged March second.

On March 1st the following blood work was done: Blood sugar 92; urea nitrogen 12.8; N. P. N. 27.6; urea clearance 3; urine 80.4 cc. per M. 106 per cent of average. Wassermann negative, twenty-four-hour urine specimen 1000 cc., urea 21 grs.

There is very little in the literature about this condition. We know that a foetus will die due to chronic nephritis or syphilis. This case certainly showed no possible nephritic involvement. Syphilis is not so easy to rule out. A negative Wassermann in a woman in the childbearing period is valueless. Husband was negative. Very frequently no reason can be given for this condition. My grandfather taught that K. I. given in maximal doses often obviates this condition. Both he, my uncle, E. J. Ill, and my father, Dr. Charles Ill, have used this for the past ninety years, often with very good results. I have no figures, but would like to cite two cases:

Case 1. The patient had two miscarriages at six, and three months; then a live baby, followed by seven miscarriages from three to six months. Patient then had a slight stroke; and was given potassium iodile for two years, when she again conceived. She did everything, expecting a miscarriage, but carried very easily to term, and delivered a beautiful boy. Both hers and her husband's Wassermanns were negative. She was a divorcee, and her first husband was quite a man about town who could easily have had syphilis. I gave this girl potassium iodide, but she admitted she rarely took it during the pregnancies.

Case 2. The second case had three miscarriages from three to four months. I saw her first with the last miscarriage. At the start of her next pregnancy we gave her potassium iodide and she went to term and delivered twins.

Progesteron is given to prevent miscarriages. Apparently its only function is to stop contractions in an irritable uterus. It is still in its infancy, and should be used with caution. (Falls, Lukins.)

Wheat germ oil (E. M. Watson & Tew) has been used, and apparently is of some assistance in preventing habitual abortion.

Horner in a recent article discussed antepartum foetal deaths, and divides them into two classes: 1, Those before quickening; and 2, those afterward.

Before quickening, a diagnosis of pregnancy has first to be made; and if the foetus dies, a negative A. Z. test is of value, but this may remain positive for three months (Bishop).

After quckening, an x-ray will show overlapping foetal bones in the cranium. This is almost a positive diagnosis of foetal death. Also, Horner tells of a peculiar silence over the abdomen; a stillness which is characteristic of foetal death.

Treatment of missed abortion is entirely expectant. If there are no symptoms, and there very rarely are any, leave the patient alone and she will eventually go into labor, often waiting until her time is up. Then the whole foetus, placenta, and everything else in the uterus will come away together. Horner cites a case of abdominal pregnancy in which the baby died, and was only removed two years afterward. At this time it was a very simple operation.

ADDRESS OF WELCOME TO THE AMERICAN HOSPITAL ASSOCIATION

ATLANTIC CITY, MONDAY, SEPTEMBER 13, 1937

By William G. Herrman, M.D., Asbury Park, N. J.
President, The Medical Society of New Jersey

Your Excellency, Governor Hoffman; President Munger; Miss Hamilton, and Distinguished Guests; and Fellow Warriors:

The headlines of the morning paper shriek of war to the east of us and to the west of us. We too are warriors, but in a fight against disease, not against our fellow men. We want to save life, not destroy it. We want to save homes, not wreck them. We want to bring little babies into the world, not spear them with bayonets. So,—we are warriors, but we fight *for* others, not *against* them.

I want to extend to you as individuals and as representatives of your institutions a most hearty welcome to our city. We are proud that you have become our guests, even for a short time. We know that you could not have chosen a better city for your convention,—I need not tell you why, because the representatives of Atlantic City have no doubt impressed this upon you in the past and will continue to do so while you are here. *I* happen to come from Asbury Park. We hope that your scientific meetings will develop improvements in hospital management and the care of the patient that will be of benefit to every part of the United States. We know that many of you will obtain valuable ideas from the commercial exhibits. We want you all to have a good time.

I personally am enjoying this moment very much—I am going to have an opportunity as a physician to tell you hospital folks some things I have wanted to say for a long time, and have either not had the opportunity or the nerve to say them at home. Dr. Munger very courteously granted me enough time to say a thing or two, and I shall take full advantage of it.

The outfit with which I went overseas travelled on the Acquitania without convoy. After we had become adjusted to our surroundings and to every nook and cranny in the ship; after we had become accustomed to the closing of all portholes and the dousing of all lights on deck after dark; after we had become tired of runing to the fore and aft batteries and talking to the lanky Alabamians who manned the guns, each with a little cross of St. Andrew stuck in the breech-lock, because you know those boys from "old Alabam" hoped to release one or two damned-Yanks as well as the Germans; after we had become tired out by running up one flight of stairs and down another in a crazy sort of merry-go-round lifeboat drill, only to find ourselves in the back row behind

two rows of nurses, Colonel Jones finally decided it was time to have a few staff conferences. I will never forget the first. "Gentlemen," Colonel Jones said (and his name really was "Jones"), "this boat may or may not be sunk by a submarine. If it is, what I have to say will be no concern of yours; but if you land on the other side, you will find a great shortage of materials, and that includes hospital materials. Major Grant, who belongs to another outfit on board, is going to demonstrate to you how to tie all kind of intricate knots from very short pieces of suture material. I want you to learn these manipulations, because you will not be able to tie a small knot with a long piece of catgut and throw the ends on the floor." Major Grant then proceeded to demonstrate, with a pair of artery clamps, deep in the folds of a napkin, how to tie all the various surgical knots with pieces of catgut two to four inches in length.

The demonstration made a great impression upon me. I tell it to you now to illustrate the waste that goes on in every hospital, not only in catgut, but in gauze, in bandages, in drugs, in chemicals, in x-ray films, in all of the expensive supplies you know so much more about the cost of than I do. This is unnecessary. How can it be eliminated? I have been connected with one of the institutions I serve for some eighteen years. During that time I have many times suggested that there be several meetings a year between the medical board and those active in hospital administration, not in the institution, but in the evening—a semi-social and semi-business meeting, in which the attending physicians and the hospital management could become better acquainted and could freely and unofficially discuss each other's problems. In too many institutions the medical staff understands all too little of the financial and administrative woes that you people know so much about. Isn't that true? We too have our hospital worries; and too often you seem uninterested so far as we are concerned. I *know* that's true. If we both understood the other fellow's viewpoint, a much better esprit de corps would be established. There would be more attempt on our part to be saving and not wasteful; there would be more effort on your part to be sympathetic and coöperative; and the person we both serve, in other words, the patient, could not help but benefit.

"Four walls do not a prison make nor iron bars a cage"; neither do they make a hospital, no matter how fine the building nor how costly and up-to-date its furnishings. What makes a hospital is the ability, the thoughtfulness and the care in its personnel, and that means everybody from the sweeper in the basement to the superintendent on the administrative side, and everybody from the nurse on probation to the chief of staff on the medical side. Mary Roberts Rinehart wrote a very thrilling story for the Saturday Evening Post, during or shortly after the war, on the exploit of Dr. Harry Kerr, of Washington, D. C., now one of the most prominent surgeons in the Capital. Dr. Kerr was a surgeon in my outfit and was ordered with a surgical team to proceed with all haste to Chateau Thierry. On his way he passed a small French chateau upon the grounds of which he saw many French and American wounded. This was a French First Aid Station. The French surgeon was shorthanded, and having been in the war three years was somewhat inured to his task and was making no particular speed. In spite of Dr. Kerr's urgent orders, he stopped with his group, raided a nearby schoolhouse, out of the chairs and tables made some improvised operating room furniture; he pounded forks and spoons into retractors, and with a few knives and artery clamps in his and his assistants' medical belts went to work and cleaned up the wounded lying on the lawn. The chateau was not a hospital, only Harry Kerr's ingenuity saw operating room materials out of what he had to work with, but by the time he was through, many a wounded man knew he had been in a first-class hospital.

The public cannot do without either you or us. The object of both the hospitals and the doctors is the same, yet sometimes their point of view and their means of attaining their end seems antagonistic. When this is so, the chief sufferer is the patient. If you did not exist, we would have to go back to the era of barnyard surgery; many of the greatest advances in both diagnosis and treatment could not be carried out. If it were not for us, you would be running only hotels for sick people.

Both the hospitals and the medical profession are facing difficult problems in these days. During the worst of the depression, both of us exhibited the true spirit of the good Samaritan; and help for the sick and injured was not withheld because of lack of funds to pay for such services and attention. When the income went down for both the hospitals and the doctors, the need for necessary services went up. This has not helped either side to understand the problems of the other, but has made it more difficult. If the staff properly appreciated your side, they would not send a patient into the lowest priced room if they believed that patient could afford better accommodations. They would be sparing in their use of ma-

terials, and in their orders for expensive drugs. They would order x-ray examinations when necessary, but not routinely in their ward services. They would not send someone into the public ward who could pay semi-private rates; they would not send patients to your outpatient department for free diagnostic workups when those patients should be paying a fee; and they would try to interest their private patients in making contributions to the institution. They should be sold the idea that the hospital is their institution as well as yours. There should be developed an esprit de corps equivalent to that which every crack military outfit proudly possesses. If you properly appreciated the position of your medical men, you would take every care to see that the men in your clinic were not treating or examining those who had no right to be there. Your surgeons wuold not be operating, without remuneration, on ward cases who ought to be in the semi-private division at least, and paying them a moderate fee; you would not be organizing diagnostic or therapeutic clinics to give service at a fee which could just as well be given in the doctor's office; and you would in no wise enter into competition with the men on your staff who are giving, in their time and service, a contribution equal to yours, in the care of your ward patients.

Our problems, after all, are not different, they run parallel. Each one finds it difficult to take care of the increasing load, with the decreasing return from the private patient, in this era of lessened philanthropy and high taxes. We cannot let down; we must go on; and with mutual understanding and full appreciation of the other's services, the burden will be lighter and the respect and support of the public assured.

I have just been through a very strenuous four weeks. I have had some things brought home to me which I have not appreciated before. I have a son in a hospital bed in Portland, Maine, at this minute who has been through a month's siege in which he has undergone three operations. I speak as an individual and from the heart, not as President of The Medical Society of New Jersey. What I am going to say now will be of interest to you. Every dollar that I have spent for nursing care has been worth two dollars, and you cannot reduce the payment for these things.

The time has come when both hospitals and physicians must give serious thought to the trend in hospital and medical care. While the cost of manufactured articles in common use today has gone down, the quality has gone up. The cost of medical and hospital care, however, has gone decidedly upward together with the quality. It is already today out of the reach of many people of moderate means, unless they are taken care of on at least a semi-charity basis. With the decline in private philanthropy due to the economic depression and the increased taxation, the need for government support has come more and more to the front. Unless we wish to meekly acquiesce in becoming institutions and agents of the government, we must all give serious thought to the means of providing modern hospital and medical care in a way that will be within the reach of those who are gainfully employed. I can see no way in which this can be done by lowering actual costs. There is entirely too much personal service involved. This personal service must be given by highly trained people who are entitled to a proper return for their service. The answer, it seems to me, must be along the lines of the insurance principle.

We must spread the cost of both medical and hospital care over a number of years; and the chance of illness must not be borne by one alone, but by a large number. The public is well sold on fire insurance for property, and on life insurance for the individual. It ought not to be hard to sell them the idea of insurance against severe illness both from the standpoint of hospital expenses and doctors' fees.

Do not take this statement of mine as an endorsement of compulsory health insurance. I am against anything of a compulsory nature. I am against prohibtions of all types. Compulsion, prohibition, and paternalism are for the enemies and wards of society, and not for society itself. I am in favor of education. A man should voluntarily work for his own support and that of his family; and neither he nor his family should be taken care of through the efforts of others as long as he is able-bodied.

I believe that physicians should first of all get back of the idea of hospital insurance, and actively act as your sales agents. This is not philanthropy. It is common sense. Your bills must be paid first. If they are taken care of through an insurance policy, the physicians then have same chance of being paid for their services.

The time will come, I venture, when there will also be insurance for medical service. Medical care in this country, I hope, will be preserved on the independent private practitioner basis, rather than the physician becoming an employee of the government or of an institution.

501 Grand Avenue

SCIENTIFIC EXHIBITS

THE SCIENTIFIC EXHIBITS OF THE 1937 ANNUAL MEETING

ARTICLE NUMBER THREE

EXHIBIT NUMBER TWELVE

THORACOPLASTY IN THE TREATMENT OF PULMONARY TUBERCULOSIS AT "BERGEN PINES", BERGEN COUNTY HOSPITAL, RIDGEWOOD, NEW JERSEY

By Joseph R. Morrow, M.D., Medical Director, assisted by the Surgical Staff: George Finke, M.D.; William Spickers, M.D.; R. M. Anderson, M.D.; R. Bernard, M.D.



Exhibit No. 12.—Thorocoplasty in Bergen Pines,—the Bergen County Tuberculosis Sanatorium

The aim of such exhibit was not only to explain to the average private practitioner in an uncomplicated and comprehensive manner the main facts about the operation of thoracoplasty, but to contrast also and to show the advantages of the new Semb's technic over the older one. The presentation was purposely plain and concise. The various steps of the operation could, in this way, be easily followed, giving an actual live demonstration of points brought out by the sketches and drawings. The latter are ink and pencil copies of the diagrams appearing in the article of R. H. Overholt entitled "Thoracoplasty with Lung Mobilization", published in the April last issue of the American Review of Tuberculosis.

The first drawing (after Rouviere) of the upper row of diagrams on the left-hand wall of the booth, photographed above, illustrates in a very clear manner the anatomy of the region of the apex of the lung. It shows the structures suspending the pulmonary apex which, in the Semb's technic, are severed allowing thus vertical collapse of the lung. These

structures are Sibson's fascia, which is an extension of the endothoracic fascia, and three ligaments or bands known as Sebileau's bands.

Alongside of the above drawing is its explanation.

The third drawing illustrates a completed first-stage thoracoplasty by the Semb's technic. Total resection of the first and second ribs and a partial one of the third rib was done. Sibson's fascia and Sebileau's bands were severed. The nerve, vessels, muscles, and periosteum of the first and second ribs were removed. The apex of the lung was freed by both blunt and sharp dissection, and "wiped down" to the level of the fourth rib. The separation was carried out extrafascially.

The first diagram of the lower row on the same wall contrasts a second-stage thoracoplasty by the older method,—that is, without mobilization of the lung,—with a two-stage thoracoplasty by the Semb's technic with lung mobilization. The operation, which was done with the intent to close an upper lobe cavity, was unsuccessful in the first instance because the collapse obtained is only lateral. The apex of the lung is still suspended by the structures mentioned above, vertical collapse is lacking, and the cavity, although smaller and slit-like, is still open and lies in the vertebral gutter. Following operation by Semb's technic, on the other hand, the structures suspending the apex have been cut, vertical collapse of the lung was obtained, and the cavity is closed.

The second diagram illustrated the necessary steps in a second-stage thoracoplasty by the Semb's technic to insure further vertical collapse of the lung and an adequate position of the new chest wall following regeneration of the ribs in a position which prevents vertical reëxpansion of the lung.

The third diagram illustrated the importance of posterior mobilization of the lung. The rib and its periosteum, the transverse process of the vertebrae, the intercostal nerve and vessels should all be resected if obliteration of the vertebral gutter and closure of the cavity are to be obtained.

On the rear wall of the booth is the screen used for viewing the colored motion pictures of the operation. Surrounding the screen are photographs of some of the hospital buildings, including the Surgical Unit. Immediately below the screen is a photograph of the operating room showing the routine "set-up" for thoracoplasty.

On the right-hand wall are the chest films and a photograph of three patients taken before and after operation. The films are mounted in glass.

Case number one (uppermost) was operated according to the old technic. The result is unsatisfactory because the apex has remained suspended, and the cavity lies in the gutter and cannot be reached by lateral collapse.

Cases two and three, on the other hand, show, in contrast, the splendid results obtained by mobilizing the lung by means of the Semb's technic. Following removal of from five to six ribs, the cavity is closed, the sputum is negative for tubercle bacilli, and the patient is well. Photographs of the patients before and after operation emphasize the fact that the postoperative deformity is rather slight. With the patient dressed, it is hardly noticeable. The use of the extremity of the operated side is conserved to a very satisfactory degree.

Running around the left and rear walls of the booth is a counter on which lie the instruments used in the operation of thoracoplasty. In addition to the identification tags attached to the instruments are small printed cards tacked on the wall above, explaining their use. These instruments include periosteal elevators, used by Dr. Alexander, Dr. Bethune, and Dr. Coryllos; rib shears devised by Dr. Bethune, Dr. Wells, and Dr. Coryllos; and rongeurs of different type, including Sauerbruck's, which is used to remove the vertebral stump of the rib and the transverse process of the vertebra. This instrument is very essential in performing the operation by the Semb's technic. Besides, various retractors and other instruments are shown.

The moving picture in color was prepared by Dr. R. M. Anderson. It was shown at frequent intervals, and explained in detail by the different members of the surgical, medical and nursing staffs.

We wish to express our appreciation to the patients who did the drawing and lettering in the illustrations.

EXHIBIT NUMBER TWENTY-SIX

THROMBO-ANGIITIS OBLITERANS

By Samuel Silbert, M.D., The Mount Sinai Hospital, New York

The exhibit on thrombo-angiitis obliterans includes sections on etiology, diagnosis, pathology, laboratory data, and treatment. In addition, some studies are presented of attempts to reproduce the disease experimentally. At the bottom of each chart is a statement emphasizing the significance of the data.

Detailed clinical evidence of the etiological relationship of tobacco to thrombo-angiitis obliterans is shown. This is supplemented by a table showing positive allergic tests to tobacco in patients with this disease. The inclusion of thrombo-angiitis obliterans in the group of allergic conditions is justified. Since a specific sensitivity to tobacco is necessary as a constitutional basis, only a small number of individuals who use tobacco develop this disease.



The exhibit also lists other types of peripheral vascular disease with which thrombo-angiitis obliterans may be confused. There are no pathognomonic signs or laboratory tests by which the disease can be identified, and it must be differentiated by its clinical features. Its wide distribution is presented to show that the diagnosis cannot be excluded because of race or nationality. A series of photographs in natural colors illustrates the usual and unusual appearances of the characteristic lesions. The use of the oscillometer and dermatherm as mechanical aids in evaluating degrees of impaired circulation is described. Impairment of circulation results from two factors: (1) The actual structural narrowing or occlusion of the lumen of the blood vessels by the disease process; (2) the superimposed vasoconstriction which is present in both normal and diseased vessels as a physiological process necessary for body heat and blood pressure regulation. The second factor is variable, and is influenced by environmental temperature and the patient's emotional state. In order to obtain an accurate evaluation of the degree of circulatory impairment in an extremity, all vasoconstriction must be temporarily abolished. This can be done by a novocaine injection into the posterior tibial nerve. Charts are presented to illustrate these points in diagnosis.

The pathological section deals with the cause of death as revealed in clinical studies and in postmortem examinations. The occurrence of thromboses in vessels of the trunk is noted, and the clinical importance of this observation is stressed. The histopathology of the vessels is presented in twelve micro-photographs reproduced from the excellent work on thrombo-angiitis obliterans by Dr. Leo Buerger.

The laboratory studies present data which reveal the following facts:

1. The blood volume in patients with this disease is reduced.
2. The blood appears to be concentrated to a corresponding degree.
3. The basal metabolism is below normal.
4. The blood sugar is normal.

The reduced blood volume and basal metabolism, and the changes in chemistry indicate that in patients with thrombo-angiitis obliterans there is a diminished function of the thyro-adrenal-gonad chain of internal glands.

The above changes have been produced in experimental animals. This is the first step in reproducing the disease. Gangrene of the toes in rats following injections of tobacco extracts is photographically shown.

The section on treatment presents the results obtained by intravenous injections of hypertonic salt solution. It is shown by comparative tables that the percentage of amputations performed has been reduced from 65 per cent, down to seven per cent. Comparison with the published results of other clinics indicates that by no other method can equally good results be obtained. Relief of pain by peripheral nerve section is described, and its indications, technic, and results are demonstrated in charts and photographs. The data of a long period of follow-up is presented to indicate that patients with thrombo-angiitis obliterans can be permanently relieved of their symptoms and remain well indefinitely after treatment is stopped.

STATE SOCIETY ACTIVITIES

ADDRESS OF THE PRESIDENT TO THE WELFARE COMMITTEE

By William G. Herrman, M.D., Asbury Park, N. J.
President, The Medical Society of New Jersey
Delivered October 3, 1937

In the August number of the Journal, page 520, was published a general program for all committees of the State Society for the ensuing year. I would now like to bring to your attention those features of the program which I feel should be emphasized. If we attempt to have too many objectives, too little may be accomplished. We have as an organization a two-fold function. When our State licenses to practice medicine were granted to us as individuals, we were immediately invested with certain responsibilities in return for certain privileges. The object of The Medical Society of New Jersey should be to unite physicians of the State in seeking to carry out, as a body, those individual responsibilities to the best of our ability and to protect and secure the privileges rightfully belonging to us.

Our *responsibilities* are to watch out for the public welfare in the realms of health; to cooperate with county, State and Federal agencies in making an effort to improve the health of our population; to seek to prevent the passage of legislation which we believe is inimical to public welfare; and to try to initiate such legislation as we believe will improve the health of our people. Under *privileges* we must seek to preserve the right to care for the ill, for those who are competent to do so, not only for the benefit of the public, but so that we may have our rightful return for the efforts we put forth in behalf of the public.

The detailed program, so far as we were able to give it to you, of each of the various committees was printed in the Journal (Sept., 1937, p. 520). I will not go into detail with regard to all of these committees, but there are four principal objectives, as I see them, for the coming year, or at least there are four objectives toward which I would like to see progress made. They are Public Health, Legislation, Hospital Relationships, and Cancer Control.

PUBLIC HEALTH

First, we are passing through a period when there is much public and private discussion as to whether or not all phases of medical practice should not be taken over by the government or quasi government agencies in the same way that many phases of preventive medicine and sanitation have already been taken over, in the same way that communication by mail has long been a function of the government, and in the same manner as we hear much discussion at the present with regard to the possibility of taking over all public utilities such as telephone and telegraph, water, gas, electricity, and even transportation.

I take it for granted that all who are in this room are anxious to see as much of private practice of medicine as remains to us now, retained. We have offered through our Public Health Committee and its advisory committees to coöperate in new phases of public health with not only the State, but the Federal government. Our offer has been accepted. We are on trial as an organization and as individuals to show that voluntary coöperation of private physicians can be as successful in these phases of public health as full-time officers of government. If we fail to demonstrate this to the satisfaction of those in authority, we must expect to see our offer of coöperation turned down, and these and every phase of public health gradually taken over by full-time government officials. It is therefore up to us as an organization and as individuals to see that such phases of our coöperation, such as the field physicians, venereal disease clinics, crippled children's work, and baby keep-well stations, are successfully operated under our supervision, and that those who accept positions in these clinics are faithful in their attendance and in their duties not for the sake of the small remuneration they receive, but in order to prove we are capable and responsible. I earnestly ask that all of you who have anything to do with the appointment of men connected with such services do everything you can to see that only those who will serve are appointed, and that those appointed who are unable or fail to serve are quickly replaced by those who will.

LEGISLATION

The second objective, as I see it, for the year is in the legislative field. We have for some time had a new medical practice act prepared, but have not felt that the time was opportune to introduce it. This new practice act, among other things, gives power to the medical examining board to revoke or suspend the license for unethical conduct of various types. This act has been prepared in collaboration with our counsel, and I take it for granted there are proper safeguards in it to prevent such power being abused. The insurance companies are very anxious to have us take such action, so that members of the profession who do abuse their rights and privileges may be brought to time. I recommend that our Committee on Constitution and By-Laws, which I believe had something to do with drawing up this act, confer with our legislative committee as to the timeliness of introducing the act already prepared or with modifications of it this year.

I would also like to see our Legislative Committee and our Workmen's Compensation Committee get together and prepare a new compensation act, or amendments to the present one which will correct some of the abuses now prevalent. In the present act, it is stated that the employer may select the "medical care" for his employees. This leaves the door wide open for the employers to appoint hospitals instead of private physicians for the care of their employees. I know of several instances where large employers of labor are sending their men to clinics for treatment. The question of whether or not the employer should designate the physician to care for the injured employee rather than the employee to have the right of selection must be very carefully considered; and if it is recommended that the employee has the right, then there certainly should be a safeguard about his selection not only for his own sake but for him who is to pay the bill. There seems to be concerted effort on foot on the part of insurance carriers to reduce the fees which we may legitimately receive for services rendered to injured employees whether treated in their homes or in hospitals.

HOSPITAL RELATIONSHIPS

The third objective for the coming year toward which I would like to see considerable progress made is that of correcting hospital relationships. We are all familiar with the great many present abuses by which hospitals practice corporate medicine and by which we who give our time free to ward and clinic cases are forced to compete with ourselves in that we treat patients in both wards and clinics for nothing who should be paying us a fee if there was a proper financial investigation.

Furthermore, physicians should have more to say in regard to hospital management and policies, and this means there should be more physician representation on boards of management and government. As you know, a survey was begun last year, but so far no report has been made as to the type of abuse commonly prevalent and no suggestions have been made as to how to correct them. I would like to see some constructive work along this line so that concrete recommendations may be made at the next annual meeting by the Medical Practice Committee.

Incidentally, along this line I might say that your President is making every effort to increase the friendliness of hospital management toward organized medicine which was started last year by President Snedecor. The State Society has endorsed the principle of hospital insurance although it protested against the inclusion of any medical service in such insurance. I have publicly recommended, both in addresses and in editorials, that we physicians be not lukewarm in our support of the hospital insurance principle, but take an interest in getting the public to purchase such insurance. If we take an active part in selling it, we have a right to speak about the type of policy sold. Furthermore, our own bills are much more likely to be paid if the patient has some relief from hospital charges which have to be met before consideration can be given to our bills. Hospital associations have taken very kindly to my endorsement of hospital insurance. We have an official member representing our Society on the Hospital Service Plan of New Jersey. I believe he can exert considerable influence to see that this group at least can put forth a hospital policy acceptable to us. If this is done, I believe that this organization and we as individuals, can be active in its promotion.

CANCER CONTROL

The fourth objective comes under the heading of Cancer Control. I am very anxious that this Society take its part in providing for all people in New Jersey, rich as well as poor, proper facilities for the modern diagnosis and treatment of cancer, and proper facilities for taking care of those beyond medical aid. A generation or more ago the problem of the medical profession was to diminish the mortality of infants and children from contact diseases and gastro-intestinal disturbances. Dr. Lewis Ryers Thompson, Director of National Institute of Health, states that thirty years ago the combined death rate in the United States

was 433.6 per 100,000 population from diphtheria, diarrhea, enteritis, scarlet fever, tuberculosis, and typhoid fever. In 1934 the rate was 83.5. The life expectancy of infants at birth has been raised materially, but that of adults is slightly lower than decades ago because cancer has come along to strike down more each year. Cancer is now claiming one-fifth more victims than it once did. Our population is changing in its percentages and this change has already affected the school system. For years we heard that more and more schools must be built. Now we are beginning to notice in the newspapers in some sections of the country there are many vacant seats in the schools, while on the other hand the proportion of those over forty to the rest of the population is steadily increasing. This alone will constantly increase those who die of the so-called degenerative diseases. As you know, cancer stands next to heart disease as the cause of death. Ninety miles apart on either side of this State are two large cities with fine facilities for the modern treatment of cancer and with welfare homes for the care of those who are beyond medical aid and cannot be taken care of at home. In this State facilities are meager outside of a few in the large centers.

I am extremely anxious that we develop a program that will bring modern diagnosis and treatment of cancer within the reach of all residents of New Jersey, and that such plan be under the guidance and direction of the State Society, and be actively supported by it with such integration of physicians and institutions treating cancer that the knowledge and facilities of one part of the State may be made available to all. I am anxious that all sufferers of cancer have facilities within easy reach of their homes because, as you know, many cases of cancer need treatment over long periods of time and it is not only expensive but a hardship for them to travel far for their treatments.

I do not mean that other phases of State activities are to be soft-pedaled. I believe the chairmen selected for all committees will be active men. I hope that these committee chairmen will not be one-man executives. I trust that they will have numerous meetings during the year so that not only an effort of several will be combined in committee activity, but the individual members of the committee may become educated in the work of the committee.

I believe that most of our active committees should be *continuing committees* in that future chairmen should be selected from those who have had experience. If the chairmen do all the work, then there is no opportunity for instruction of others in the work of any committee. Some committee chairmen have complained that members of their committees do not come to meetings. My own reply to that is that the membership of every committee which I appoint was with the advice and consent of the chairman. If he and I have been wrong in our selection, it is still possible to add to committee membership any others who are willing and anxious to serve.

PUBLIC RELATIONS

Last year we started a very important function of the State Society by establishing a committee to stimulate, to originate and to supervise our public relations. This committee in one sense of the word really has the biggest job of all, because for it to function to the highest degree, it must integrate its work with that of every other committee of the State Society. It must be familiar with the aims, objectives, and accomplishment of every committee. I trust, therefore, that the committee chairmen will not wait for the Public Relations Committee chairman to get in touch with them, but they themselves will get in touch with the chairman of the Public Relations Committee, find out what he can do for them and in turn make available to him information with regard to their work which may be advantageous to inform the public about.

In closing, I wish to emphasize the fact that the work of our Society should be an integrate whole, that the Trenton office should be informed constantly as to activities of our various committees, and that no public program should be instituted by any committee without the knowledge of the central office and the President. I am sure that we are all enthusiastic about our organization, what it has accomplished, what it stands for, and what it can and will accomplish.

W. G. H.

WELFARE COMMITTEE

A meeting of the Welfare Committee was held in the Stacy-Trent Hotel, Trenton, at two o'clock, on Sunday afternoon, October 3, 1937, with the following representatives present:

Atlantic County:	
Hilton S. Read, Chm.	Anthony G. Merendino
Myrtile Frank	
Bergen County:	
Samuel Alexander	Spencer T. Snedecor
H. B. Wilson	George M. Knowles
Camden County:	
Thomas K. Lewis	
Cape May County:	
George F. Dandois	
Cumberland County:	
H. S. Branin	Millard F. Sewall
Essex County:	
William H. Areson	Theodor Teimer
Arthur W. Bingham	Earl LeRoy Wood
Edgar P. Cardwell	Edgar A. Ill
J. Irving Fort	Walter B. Mount
John W. Gray	Frank W. Pinneo
Julius Levy	A. Charles Zehnder
Gloucester County:	
I. W. Knight	Oran A. Wood
Chester I. Ulmer	
Hudson County:	
James F. Norton	B. S. Pollak
Mercer County:	
D. Leo Haggerty	George N. J. Sommer
Allen G. Ireland	
Middlesex County:	
Henry Haywood	Jacob J. Mann
Joseph H. Kler	John Rowland
Edward F. Klein	
Monmouth County:	
J. Berkeley Gordon	Barclay W. Moffat
Morris County:	
George J. Young	
Ocean County:	
Eugene G. Herbener	Walter G. Hayden
Passaic County:	
Sigurd W. Johnsen	Fred Vosburgh
Wright MacMillan	
Somerset County:	
Frank L. Field	A. F. W. Sferra
Union County:	
Frederic W. Lathrop	Lorrimer B. Armstrong
Herschel S. Murphy	Charles H. Schlichter
Warren County:	
William H. Varney	James Weres

Also:

LeRoy A. Wilkes, Secretary to the committee
Frank Overton, Editor
William H. MacDonald, State Department of Health
Robert P. Fischelis, State Pharmaceutical Association
Donald Benson, Publicity Assistant to Dr. Kler

President-Elect Carrington read the address of President William G. Herrman, commenting on the activities of the committee. This address is printed on page 682. Dr. Herrman and a number of the Trustees were absent attending the funeral services of Dr. Blase Cole, a member of the Board of Trustees.

FIELD PHYSICIANS

Dr. Carrington also presented the report of the *Council on the Selection of Field Physicians,* and said that New Jersey is the only State in which they are chosen by the State Medical Society, they being appointed in all other states by the Federal executives of the National Security Act, and giving their whole time to their duties. The representatives of The Medical Society of New Jersey secured permission that the Field Physicians should be physicians in actual practice; and should be chosen because of their reputation for public spirit, and their knowledge of local conditions. This puts a grave responsibility on the Council to see that properly qualified doctors are chosen, so that practicing physicians shall be responsive to their suggestions and coöperative in making records and reports.

Dr. Bingham, Chairman of the Advisory Committee on Maternal Welfare, described the excellent record made by the Field Physicians, who have already started on their work, showing that 600 slips for nursing services had been turned in, and slips for fifty maternal consultations.

He also reported that every maternal death had been fully investigated, with the wholehearted coöperation of every doctor in attendance upon the patients.

The method of choosing the Field Physicians has been as follows:

1. Each county society selected three local physicians as candidates for the position, and nominated them to the State Council.
2. The State Council, consisting of Drs. Bingham, Levy, Nichols, Read, and Carrington, chose one of the three nominees and nominated him to the State Department of Health.
3. The State Department of Health made the final appointment, which was accepted by the Federal authorities.

The list of Field Physicians is as follows:

FIELD PHYSICIANS

Atlantic—J. Carlisle Brown, Atlantic City
Bergen—Lyman Burnham, Englewood
Burlington—F. D. Fahrenbruch, Mount Holly
Camden—Edmund Hessert, Collingswood
Cape May—Clarence W. Way, Sea Isle City

Cumberland—J. S. Knowles, Millville
Essex—Alfred Meurlin, East Orange
Gloucester—Chester I. Ulmer, Gibbstown
Hudson—Joseph P. Donnelly, Jersey City
Hudson (colored)—Lena Edwards, Jersey City
Hunterdon—P. W. Baker, High Bridge
Mercer—James R. Harman, Trenton
Middlesex—James Grieve, Perth Amboy
Monmouth—William Heatley, Red Bank
Morris—George L. Nicoll, Dover
Ocean—Harry Ivory, Point Pleasant
Passaic—Theo. K. Graham, Paterson
Salem—William G. Hilliard, Salem
Somerset—Samuel H. Pogoloff, Manville
Sussex—August H. Groeschel, Sussex
Union—No appointment
Warren—James Weres, Alpha

Dr. Julius Levy, Consultant in Child Hygiene in the State Department of Health, described a visit which he had made to the Washington officials of the Security Act. He said that physicians of New Jersey should realize that the system of field physicians in this State was not a step toward nationalized control of medical practice, but the *surest preventive* of it.

Dr. Levy also said that the basis of appointment of a field physician by the Federal authorities was his standing in courses in public health, largely didactic; but that the basis of his appointment in New Jersey was his experience and ability as certified by his confreres in his county medical society.

PUBLIC RELATIONS

Dr. J. H. Kler, Chairman of the Sub-Committee on Public Relations, reported the recent developments of the accomplishments of his committee in popular publicity of medical subjects under four classifications.

1. NEWS BULLETINS

1. Secretaries' bulletins had been prepared on nine subjects for the use of speakers before popular audiences. Each bulletin consists of two parts:

a. An address on a particular subject designed especially to be given before a "Service Club", such as the Kiwanis or Rotary.

b. A news release to be sent to the local newspaper describing the lecture.

Dr. Kler explained that the lecture was not intended to be read; but the speaker could use it as a guide in explaining its points in his own words.

The bulletin is not a "pronouncement" of the Medical Society, but is purely informative of the general principles which actuate all family doctors in their attitude toward a given class of patients.

Dr. Kler distributed an outline of the first Bulletin, and also its text, and a newspaper outline to be given to the local press after the lecture. The outline of the address was as follows:

"Why Service Clubs Should Be Interested in The Medical Society of New Jersey"

I. Three great similarities between service clubs and The Medical Society.
   1. Purpose
   2. Methods
   3. Problems.

II. Public Health most important problem.

III. The Society's preventive medicine program.
   1. Problem—to secure coöperation of lay public.
   2. Fields of concentration.

IV. How the public benefits from the Medical Societies' organization.

V. Relation of the County Medical Society to the State Society.

2. THE PACKAGE LIBRARY

Dr. Kler next described the "Package Library", which the committee is collecting along two lines:

1. Scientific Medicine.
2. Popular topics, consisting of articles from such sources as "Hygeia". These may be used by local speakers in preparing their addresses.

3. NEWSPAPER PUBLICITY

News articles, and particularly a column of questions and answers for the use of weekly newspapers. One on heart disease has been sent out, and widely used by the local weeklies.

4. RADIO BROADCASTS

The committee is making contacts with broadcasting stations, but is encountering minor difficulties which will soon be solved.

There was considerable discussion in regard to the details of the radio talks,—their form and contents, and the attitude of family doctors to the personal publicity which necessarily follows a talk given by a local doctor. These difficulties vanish when the speakers understand their subjects.

Dr. Kler suggested the desirability that each county society should appoint a committee whose duty would be to advise local librarians regarding books and other literature to be placed on the shelves and reading room tables for the benefit of their readers.

NURSING ATTENDANTS

Dr. A. Charles Zehnder, Chairman of the Sub-Committee on Nursing and Nursing Education, described the approaches which the committee had made to several nursing organizations in the State, and found that their interest centered in developing fully trained nurses who are capable of giving expert service in surgical operations and severe cases of illness. Dr. Zehnder had also approached organizations giving vocational training and found them to be receptive to the plan of giving training to "Nursing attendants".

Dr. Zehnder asked for an expression of the members of the Welfare Committee toward the project of training nursing attendants. The vote was unanimous in favor of the project.

THE CENTRAL EXECUTIVE OFFICE

Dr. LeRoy A. Wilkes, Executive Officer of The Medical Society of New Jersey, gave a brief address on the great progress in the mechanics for doing the work done in the Executive Offices, particularly in receiving, coordinating, and distributing the great mass of information which flows into and out of the Executive Offices. The staff of the office is now well informed of the work of the county societies. The State Society is now well organized to deal with all the major problems which confront the medical profession in all parts of the State.

The next great item of progress will be to place its wealth of experience at the disposal of the county societies so that they will bring their services up to the highest standard of efficiency. Events have happened with a rapidity which is sometimes confusing to the members throughout the State. The House of Delegates has approved a budget for the employment of a "Field Representative", who shall explain the plans and methods of the State Society, and adapt them to local needs and conditions. But in order that the work of coordination may develop logically and smoothly, it is planned that Dr. Wilkes, or one of the central staff, will be ready to respond to calls from the officers of county societies to come to them and explain the standard methods which the State leaders have found by experience and consultations to be practical and efficient.

The Welfare Committee adjourned at 4 o'clock after two hours of intensely practical discussion devoted principally to the needs of the several county societies and practical methods of supplying them.

THE EVOLUTION OF THE WELFARE COMMITTEE

The Welfare Committee of The Medical Society of New Jersey was first suggested by Dr. Thomas W. Harvey in his Presidential Address at the Annual Meeting on the evening of Tuesday, June 24, 1919, when he said (Journal, July 1919, p. 224):

> There should be established a new Standing Committee. I do not know what its specific title should be, but its purposes should be those of an active agent in forwarding the welfare of the profession. Its duties should be:
>
> 1. To complete the organization of the profession. (Enroll new members.)
>
> 2. Represent the united profession in conferring with Employers' Associations, Labor Unions, and Insurance Carriers in all matters affecting the status of medical men or their remuneration (referring specifically to the Workmen's Compensation Act).
>
> There is no reason why the doctors should not be represented in all conferences when such questions as Workmen's Compensation Insurance or Health Insurance are discussed, because all such measures depend for their success upon the work of the medical men; and consequently the doctor should decide what he will do, how he will do it, and what he will be paid for his services.
>
> 3. This committee shall have for its duty, in the event of the adoption of social insurance by the State, to so direct legislation that all hospital and dispensary staffs shall be salaried. * * * The State should pay for all medical charity work if it pays for any.
>
> These three very important duties cannot be taken over by any of our present standing committees. Such a committee should not be composed of ex-Presidents of this Society. It should draw to its membership the virility of youth, men who are aggressive and who will be ready to combate the aggressions of the new era of class wars that seem ominously threatening as an after-war result.
>
> No class can govern the world without the assistance of the doctors. Therefore we must be prepared to meet all the social changes, and to develop an authoritative agency that will be ready to act quickly; and if necessary through a business agent and efficient counsel.
>
> If the world's work is to be done by collective bargaining, we must be prepared to meet the situation.

In the Wednesday morning session, Dr. David C. English, Secretary of the Board of Trustees, introduced the following resolution, which was adopted:

Resolved, that a committee of five be appointed by the Chair, of which President Harvey shall be Chairman, to consider the recommendation contained in President Harvey's address; and that the committee shall have full power to adopt and carry out any measures which they deem proper, at such expense to the Society as the Board of Trustees shall approve.

The committee that was appointed consisted of:

T. W. Harvey, Chairman, Orange
H. B. Costill, Trenton
D. C. English, New Brunswick
J. C. McCoy, Paterson
W. P. Eagleton, Newark

The first reference to the Welfare Committee is found in an editorial in The Journal of October, 1919, p. 371, in which Dr. D. C. English, Editor, says:

We believe it (suppression of pretenders and quacks) is one of the most important subjects that can be considered by the committee that was appointed at the last annual meeting on the Welfare of the Profession, because the welfare of the profession is best maintained and advanced as the profession realizes that *its* welfare will be best promoted by zealous and persistent efforts for the welfare of *the public.*

Newspapers accept advertisements of quacks, and then deny the use of the columns to physicians to inform the public of the falsity of the claims of the pretenders. Seeking the Welfare of Humanity is the highest, best aim of our efforts to secure the Profession's Welfare.

Another reference to the Welfare Committee is found in The Journal of January, 1920, p. 32, which prints a letter from Dr. John S. Yates, of Paterson, commending Dr. Harvey's promotion of a committee to guard the welfare of the medical profession.

The next reference to the Welfare Committee is found in The Journal of February, 1920, which contains an editorial item stating that Mr. Joseph H. Gunn, of Newark, had been employed as the representative of the committee and the State Society, and that his duties will be:

1. To complete the organization of a "Committee of five" in each county similar to the Welfare Committee of the State.
2. To protect the interests of the profession in all matters that may come up before the State Legislature.
3. To visit each county in the State in order to enlist the coöperation of their officers.

The report states that three legislative bills now require the attention of every doctor.

On the same page is also a report on legislative matters to the Trustees, who made an appropriation of $1000 for expenses.

The first report of the Welfare Committee to the House of Delegates is printed in The Journal of July, 1920, and is entitled "Report of Committee on President's Address; later known as the Welfare Committee".

It is to be noted that the word "Welfare" had been used as the name of the committee throughout the previous year.

The Transactions of the House of Delegates, in The Journal of September, 1920, pp. 313-317, contain a discussion of the functions of the Welfare Committee and of a proposed By-Law establishing the Welfare Committee, and authorizing it to employ a "Special agent". This By-Law was adopted as follows (p. 326):

The Welfare Committee shall be composed of at least five members to be appointed by the President. One of these members shall be the executive officer of the committee and shall receive a salary. The duties of this committee shall include the work of the Committee on Legislation (Chap. IX, Sec. 6), and to it shall also be referred all questions of professional welfare not included in the specific work of the Judicial Council. This committee shall establish a close alliance with the county medical societies, shall be empowered to employ a special agent or agents, and to expend such moneys as may be approved by the Board of Trustees. This committee shall file monthly reports of its work with the Secretary of each component society in this State.

Immediately after the adoption of this By-Law, Mr. Gunn, the paid executive of the committee, was introduced to the House of Delegates (Transactions, 1920, p. 326).

The Journal of July, 1920, p. 242, reports the first meeting of the Welfare Committee after the Annual Meeting of the House of Delegates held on June 15-17, 1920. It was held on June 30, 1920, and Dr. Wells P. Eagleton was elected Chairman, for "Dr. Harvey, who had served so faithfully and efficiently the past year, asked to be relieved, but was assigned important work".

The committee planned to stimulate the activity of a Welfare Committee in each county society.

The committee appointed in June, 1920, consisted of:

Wells P. Eagleton, Chairman, Newark
Henry B. Costill, Trenton
David C. English, New Brunswick
Thomas W. Harvey, Orange
Donald Miner, Jersey City.

Members afterward added were (Jour., May 1921, p. 162, and October 1921, p. 334):

A. F. McBride, Paterson
J. Hunter, Jr., Westville
Frederick Morrison, Newton
Horace L. Rose, Camden
Frederic J. Quigley, Union City
Stephen Quinn, Elizabeth
Frank W. Pinneo, Newark
William J. Carrington, Atlantic City
James J. McGuire, Trenton
Edwin Field, Red Bank

The Journal of January, 1921, page 22, contains an address of Dr. Eagleton, Chairman of the Welfare Committee, before a conference of the State and county welfare committees

In his report to the House of Delegates in 1923 (Jour., September 1923, p. 317), Dr. Eagleton reported on the following subjects:

Medicine in relation to education.
Venereal disease control.
Chiropractic legislation.
Workmen's compensation.
Nursing.
State medical laws.
State medicine.
Expert medical testimony.

In closing his report to the House of Delegates, Dr. Eagleton made the following suggestions (Jour., September 1923, p. 320):

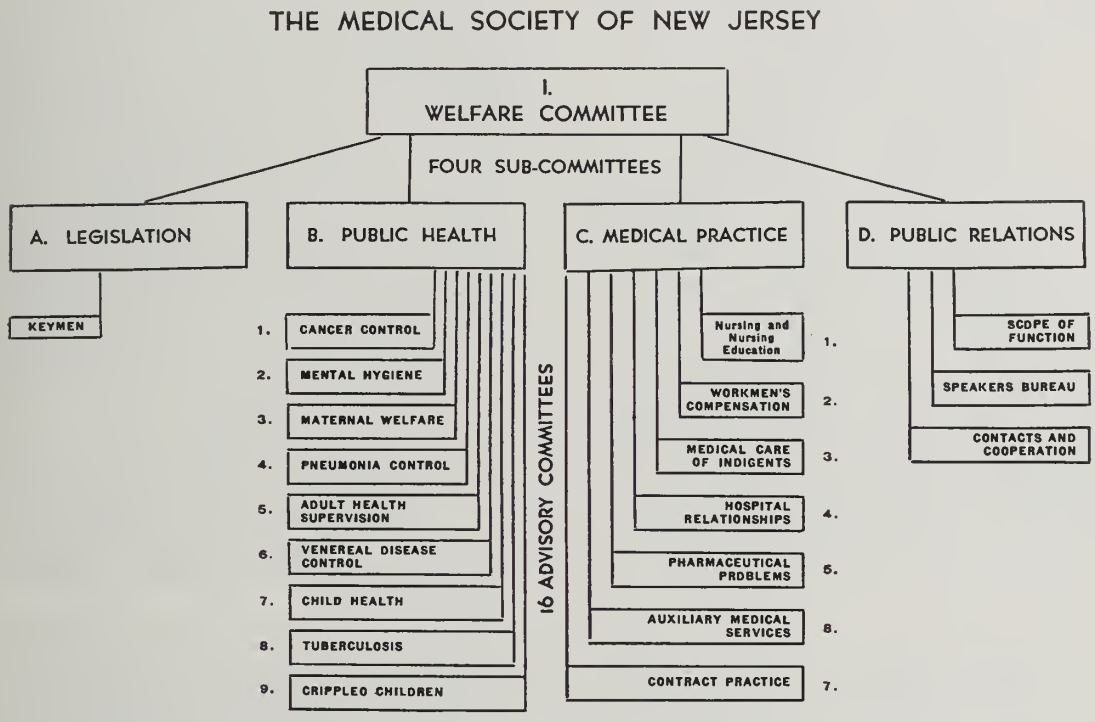


Diagram of the form of organization of the Welfare Committee on November 1, 1937

held in Trenton on December 14, 1920, in which he advocated the appointment of physicians on the governing boards of fourteen State institutions that have medical functions.

In the fourth annual report of the Welfare Committee to the House of Delegates on June 21, 1923 (Jour., September 1923, p. 318), Dr. Eagleton reported that a conference of the committee had been held with the Governor, and that the Governor had appointed an Advisory Board of five physicians to advise the Governor and the heads of the State Departments regarding all medical matters. Dr. E. J. Marsh was named Chairman of the Advisory Board. This project does not seem to have been continued.

1. Develop a definite program.
2. Secure representatives from each county society who would promise to attend one meeting each month for eight months.
3. Form sub-committees on Medical Practice, Workmen's Compensation, Venereal Disease Control, Sterilization.
4. Have a paid executive.
5. Issue periodic bulletins to all members of the State Society.

Dr. Eagleton remained Chairman of the Welfare Committee after he was elected President of the State Society in 1923; and in 1924 he made a verbal report to the House of Delegates (September Supplement, p. 19); and a more extensive report as the principal part of

his presidential address (Jour., November, p. 337).

The 1923 and 1924 reports of Dr. Eagleton are landmarks in the development of the Welfare Committee. While in previous years legislation had been its principal activity, from this time forward other public relations of physicians were prominently considered; sub-committees were established; and the activities of the Welfare Committee were broadened along the lines which have been followed ever since.

In the Fall of 1924, Dr. A. F. McBride succeeded Dr. Eagleton as Chairman of the Welfare Committee, and in 1925 he gave a report which is printed in the Transactions (Supplement to August Journal, p. 43). In it he describes the formation of sub-committees on:

Medical Practice Act.
Juvenile Delinquency.
Medical Expert Testimony.
Workmen's Compensation.

On October 1, 1924, the Board of Trustees engaged Dr. Henry O. Reik to be editor of the Journal, and secretary and publicity executive of the Welfare Committee (Jour., Nov. 1924, p. 304; and Sup., Aug. 1925, p. 10).

At the meeting of the Welfare Committee on December 20, 1925, reported in the Journal of February, 1926, p. 88, Dr. Reik gave a three-page report of his activities, going into details. This seems to be the first meeting at which a long list of matters of general interest came before the Welfare Committee. Dr. Reik continued this custom in succeeding meetings, and his reports constitute the major portion of the records of the committee.

When Dr. McBride became President of The Medical Society of New Jersey in 1929, Dr. A. Haines Lippincott was elected Chairman, and served for three years. Dr. C. H. Schlicter became Chairman in 1932, Dr. Frederic J. Quigley in 1933, and Dr. T. B. Lee in 1934. Dr. H. S. Read, the present Chairman, was elected on October 20, 1935.

THE PRESENT SCOPE OF ACTIVITIES

Beginning in 1933 the Welfare Committee underwent a rapid evolution and expansion in its organization, with the consent and approval of the Board of Trustees. Reports of these developments were approved by the House of Delegates in successive years, and were printed in the annual Transactions. It was the policy of the committee to take notice of the newer fields of medical practice, and to suggest sub-committees on each group of activities, and also advisory committees in each new activity. These appointments were made by the President with the approval of the Board of Trustees, until the system was fully organized as shown in the accompanying chart. This form of organization was incorporated in amendments to the Constitution and By-Laws by the House of Delegates at the Annual Meeting, April 27-29, 1937.

The completed organization of the Welfare Committee enables the Society to take up any new line of work which may require attention. When a new activity is contemplated, an advisory committee is appointed whose purpose is to study the field and devise methods of dealing with the situation.

Each advisory committee reports to the sub-committee; and the sub-committee reports to the Welfare Committee. Every new activity is ultimately considered by the Welfare Committee, thereby insuring its full consideration with respect to its relations to all the other activities of the State Society.

Over 150 members serve on the Welfare Committee and its subordinate committees, at least one coming from each county society. The committee is therefore truly representative of the attitude of the county societies and their members.

An objective of the Welfare Committee is that the county societies shall appoint committees similar to those of the State Committee, as several have already done. The great practical value of the perfected organization is that it affords the means of securing a coördinated action of all the committees and members in dealing with Federal authorities who seek to control all forms of medical practice among the indigent and the low-wage groups.

NEW JERSEY TUBERCULOSIS LEAGUE

The thirty-first annual meeting of the *New Jersey Tuberculosis League* was held in the Woodrow Wilson Hotel, New Brunswick, on Friday, October 22, 1937. The program was prepared by a committee, of which Dr. J. H. Kler, New Brunswick, Chairman of the Public Relations Committee of The Medical Society of New Jersey, was Chairman, his associates consisting of Drs. Stephen A. Douglas, Paterson; LeRoy A. Wilkes, Trenton; Grace M. Kahrs, Newark; William J. Ellis, Trenton, Commissioner of Institutions and Agencies,

and Laura H. Woodhul. The attendance was very large—over five hundred at a conservative estimate.

The meetings were held in five sessions, four being on the administrative phases of anti-tuberculosis work, and one on the purely medical phases.

The first session was held at 9:45 a. m., and was addressed by William A. Doppler, Ph. D., Health Education Service, National Tuberculosis Association, who emphasized the "Early diagnosis campaign", and the responsibility of citizens generally to assist in the campaign for treating known cases according to the rules of epidemiology. Emotion and social attitudes are major factors which must be considered in securing action by the people—and these factors are the responsibility of civic officials and welfare organizations, as well as physicians.

The second session was held during luncheon and was addressed by Dr. J. Arthur Myers, Minneapolis, President of the National Tuberculosis Association. Dr. Myers described the responsibility of citizens generally in providing work adapted to the strength of the patient. He paid a high compliment to employers of labor for their earnest endeavors to provide gainful employment for their tuberculous employees.

Dr. Henry H. Kessler, Medical Director, New Jersey Rehabilitation Committee, described an encouraging experiment in the rehabilitation of patients discharged from the Essex Mountain Sanatorium.

The third session was held at 2:15 p. m. in the ballroom, which was filled to overflowing. The general subject was "Case-finding in schools",—a problem that is primarily medical, but requires the active coöperation of school officials, civic groups, and welfare organizations. The Medical Societies are to furnish the expert diagnosticians, and the other groups to supply the clerical help and the finances.

The speakers described the special methods which are adapted to finding cases among four groups:

1. Negroes.
2. Kindergarten and lower grade school children.
3. High school scholars.
4. College groups.

The addresses were along the lines described in The Journal of October, page 637, in which the case-finding methods and organizations in Bergen County were given in detail.

The fourth session was a *Christmas Seal Pep Dinner,* held in the evening, with the speaking interspersed with entertainment.

The fifth session was purely medical, and was held in the Roosevelt Hospital, Metuchen, the Tuberculosis Sanatorium of Middlesex County. Demonstrators showed the method of tuberculosis testing, and of interpreting the results. The reactions were shown on patients who had been injected a few days previously.

The principles of the interpretation of x-ray plates of the chest were also demonstrated.

The meetings were promptly conducted and were well adapted to inform all groups of tuberculosis workers regarding all phases of their work.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS SINCE JULY 1, 1937

DIPHTHERIA TOXOID

County	To Aug. 31	Month of Sept.	Total to Sept. 30	Average per Month
Atlantic	3	21	24	8.
Bergen	140	193	333	111.
Burlington	31	28	59	19.6
Camden	66	34	100	33.3
Cape May	3	9	12	4.
Cumberland	26	479	505	168.3
Essex	642	391	1033	344.3
Gloucester	93	9	102	34.
Hudson	37	10	47	15.6
Hunterdon	0	2	2	.6
Mercer	12	177	189	63.
Middlesex	97	71	168	56.
Monmouth	255	31	286	95.3
Morris	74	23	97	32.3
Ocean	21	0	21	7.
Passaic	453	130	583	194.3
Salem	20	29	49	16.3
Somerset	239	5	244	81.3
Sussex	1	0	1	.3
Union	162	148	310	103.3
Warren	40	8	48	16.
Totals	2415	1798	4213	1404.3

SMALLPOX VACCINE

County	To Aug. 31	Month of Sept.	Total to Sept. 30	Average per Month
Atlantic	15	312	327	109.
Bergen	429	137	566	188.6
Burlington	84	96	180	60.
Camden	101	447	548	149.3
Cape May	4	27	31	10.3
Cumberland	123	126	249	83.
Essex	742	713	1455	485.
Gloucester	166	96	262	87.3
Hudson	19	36	55	18.3
Hunterdon	9	4	13	4.3
Mercer	14	150	164	54.6
Middlesex	124	203	327	109.
Monmouth	390	316	706	235.3
Morris	34	173	207	69.
Ocean	0	5	5	1.6
Passaic	480	335	815	271.6
Salem	85	113	198	66.
Somerset	236	7	243	81.
Sussex	0	0	0	0.
Union	455	773	1228	409.3
Warren	84	88	172	57.3
Totals	3594	4157	7751	2583.6

COMMITTEE ON POST-GRADUATE EDUCATION

A meeting of the Committee on Post-Graduate Education was held on Sunday, October 24th, 1937, at 2:15 p. m., in the Executive Offices, Trenton. The Chairman, Dr. Satchwell, presided. Those present were Drs. Satchwell, S. Hawkes, E. Z. Hawkes, Kleiber, Barlow, Herrman, and Wilkes; also Dr. Murray, Chairman of the Sub-Committee on Preventive Procedures and Child Health of the Committee on Public Health; and Professor Light, representative of the Extension Division of Rutgers University.

The Committee on Post-Graduate Education has divided its program into three parts:

1. Post-Graduate Education.
2. Public Health Education (Social Security Act Program).
3. Collateral Activities.

1. POST-GRADUATE EDUCATION

This year, as heretofore, post-graduate education will be given, in coöperation with the Extension Division of Rutgers University; and will be pay courses. The State Society up to this time has not seen fit to cancel the agreement with Rutgers University in carrying out this course as a coöperative program.

As in past years, Post-Graduate Education will be the equivalent of fourth year medical-college teaching given in six lectures at eleven centers in the State; the centers to be those we have established in the past. Courses will be given in coöperation with Rutgers University Extension Division as *paid education,* it being noted that Rutgers University by virtue of its charter cannot give free education. The charge this year will be the same as last year, a total of $250.00 for courses of six lectures. Individual subscriptions are to be decided upon by each County Society committee. The plan, as in the past, of using lecturers from universities about us will be again followed. All activities of the Committee on Post-Graduate Education that are given without cost will have no connection with Rutgers University.

The Extension Division of Rutgers University agrees, as outlined in a plan presented by Professor Light, to take care of all matters of organization, printing, and mailing; bills will be paid by them from money received from each County Society. If there should be deficits, such deficits will be made up by the Extension Division of Rutgers University.

The Post-Graduate Education Committee will work through the university office in setting up these courses. Professor Light will, in the near future, visit the Post-Graduate Education Committee of each County Society; and, as in other years, will allow each committee to select the lecturers and subjects for the courses. Certificates will be given by Rutgers University and The Medical Society of New Jersey jointly, if requested by each County Society. Notice of Professor Light's visits to each County Society Committee will be sent out in the near future, and it is planned to give the courses shortly after the first of the year. Definite effort will be made that there will be no interference by the Rutgers courses with the other activities of this committee.

Dr. Barlow moved that the plan outlined above be accepted by this committee as the plan for the coming year in Post-Graduate Education. Dr. Kleiber seconded the motion. Unanimously carried.

2. PUBLIC HEALTH EDUCATION

Public Health Education courses will again consist of lectures given at the same centers as established for post-graduate education, and will be chiefly on preventive medicine or public health subjects. The lectures can be divided into:

a. Maternal Welfare.
b. Child Health.
c. Venereal Disease Control.
d. Tuberculosis Prevention.

a. This year we have had no request from the Maternal Welfare Committee to give any lectures for that committee.

b. Last year at five centers, courses of five lectures each were given on *preventive procedures in child health;* and the program for last year was devoted to the first year of life. This year the same centers will be used with courses of five lectures, and lecturers from universities in New York and Pennsylvania will again be used.

The year's program will be devoted to *the Pre-school Age.*

It is planned to have this program follow the paid courses in the spring, which has been found to be the best time of the year and most desirable to men in rural sections of the State.

Dr. Murray stated that centers would be in Monmouth County, probably Asbury Park, Camden, Atlantic City, Somerville, and probably Hackensack. Thirty dollars per lecture to each speaker, including traveling expenses, will be paid by the State Department of Health. The time of the lectures will be the last two weeks in March, and all of April. The time of the week for the courses will be decided by the County Societies.

Dr. Murray's Committee on Preventive Procedures will prepare and furnish the Committee on Post-Graduate Education the suggested curriculum, in conformity with which the lectures shall be patterned. The committee under Dr. Murray shall also secure lecturers requested by the Committee on Post-Graduate Education. The responsibility for all expenses of operation of these courses shall be carried by the Sub-Committee on Preventive Procedures and Child Health. These finances are obtained from funds available under the Social Security Act to the State Department of Health which is operating in coöperation with The Medical Society of New Jersey in a program designed and sponsored by both groups.

The actual organization and operation of these courses will be carried out through the Executive Offices in Trenton. The proposed curriculum will be published in the Journal as soon as it is practicable to do so. This program is a coöperative note between the Medical Society, the American Academy of Pediatrics, Committee on Public Health, and the State Department of Health under Dr. Julius Levy, Consultant to the Bureau of Maternal and Child Health.

Dr. S. Hawkes moved that the above plan and policies be adopted by this committee to guide the Public Health Education activities of the Committee. Dr. Kleiber seconded the motion. Unanimously carried.

c. In the very near future the Chairman of this committee will have a conference with Dr. Wilkes, Executive Officer, and Dr. Nichols, Chairman of the Public Health Committee, to outline a plan for lectures at county meetings, the courses of lectures to be whichever may be deemed advisable, for the purpose of giving some education in venereal disease control this year. Plans at this time are only tentative; but when formulated they will be published in the Journal.

d. A conference will be held between the Chairman of the Advisory Committee on Tuberculosis and the chairman of this committee in order to plan to give lectures of educational value, if possible, along these lines.

3. COLLATERAL ACTIVITIES

Collateral activities include all those which are not related to Rutgers courses, or courses in preventive procedures for the pre-school-age child. It has always been the policy of this committee to aid County Societies to carry out their own programs where they have shown a desire and ability to do so. This policy will be followed again; and the committee desires to state that for the third year Bergen County has arranged post-graduate education courses of lectures to be given and financed by itself. These courses will be given at a time so as not to interfere with course of preventive procedures and child health at the same center.

It is the earnest request of this committee to other county societies to carry out as much post-graduate education as can be done on their own initiative. Courses are being arranged in Essex County this year by the county society, the plans of which when formulated will be published in the Journal. The courses will be clinical and practical as far as possible.

Last year this committee was requested by President Snedecor to plan practical and didactic courses in fractures to be given by each county society in coöperation with the A. M. A. Dr. Snedecor again requests that this be done; and in the near future this committee will have a conference with the Fracture Committee of the A. M. A. to carry out this suggestion as far as possible.

Dr. Herrman suggested that this year, whenever possible, the educational meetings of the various counties be carried out in the form of round-table discussions to promote intimate contacts between the lecturers and their audience.

Dr. Herrman suggested that this committee make and publish a list of hospitals having post-graduate clinical facilities in teaching centers which are available to visitors; any man who is unable to fit his time to the list published should contact the committee for some other arrangement.

The meeting adjourned at 3:30 p. m.

HARRY H. SATCHWELL, M.D.,
Chairman.

ANNUAL MEETING

The 172nd Annual Meeting of The Medical Society of New Jersey will be held in the Ambassador Hotel, Atlantic City, on May 17, 18, and 19, 1938. Although the Society had been accustomed to meet in Haddon Hall, that hotel has been engaged by other organizations during the weeks which are convenient to the physicians. The Committee on the Annual Meeting, and the Sub-Committees on the Scientific Program and the Scientific Exhibits are now at work on the details of the programs and the arrangements.

CONTACTS AND COMMENTS

COMING EVENTS

The Tustees have decided to hold the Annual Meeting of The Medical Society of New Jersey on May 17, 18, and 19, 1938, in the Hotel Ambassador, Atlantic City, as announced on page 693.

The Annual Conference of the Secretaries and Editors of the State Medical Societies will be held under the auspices of the A. M. A. in its building in Chicago, Ill., on November 19 and 20, 1937. The expenses of the representatives are paid by the A. M. A. New Jersey will be represented by Secretary Stahl, Executive Officer Wilkes, and Editor Overton. Dr. Wilkes is on the program for Friday afternoon to give an address on the subject "New Jersey's Coöperative Program for Maternal and Child Health".

The practical character of the Conference will be appreciated from a reading of the description of last year's conference on page 726 of the December, 1936, issue of this Journal.

Dr. Walt P. Conaway, 1723 Pacific Avenue, Atlantic City, President of the American Medical Golfing Association, has sent out the following announcement:

A "Golfers' Special" to the San Francisco meeting of the A. M. A. is being organized by the American Medical Golfing Association. Physicians who like golf mixed with their travel will find five games arranged on the trip out to the coast for the A. M. A. meeting of June 13, 14, 15, 16 and 17, 1938, and three games on the return trip through the Northwest. The first game will be played in New Orleans, reached by the Steamship S. S. Dixie, from New York (or via a rail itinerary) on Tuesday, June 7, 1938. Other stops include Houston, Galveston and San Antonio, Texas; Los Angeles and Del Monte, California; and finally San Francisco, where the big A. M. G. A. tourney will be held on Monday, June 13, 1938.

The return trip includes Portland, Oregon; Seattle, Washington; Vancouver, B. C.; Lake Louise and Banff; and finally St. Paul and Chicago.

Non-golfers as well as golfers, and their ladies, are welcome, and will find the A. M. G. A. Special a glorious experience.

For full particulars write Dr. Walt P. Conaway, President.

Members of The Medical Society of New Jersey are reminded of their opportunity to join the fifteen-day West Indies Cruise of the Pan American Medical Association, from January 15 to 31, 1938, as described in this Journal of October, page 640.

THE NEW JERSEY HEALTH AND SANITARY ASSOCIATION

The sixty-third annual meeting of the *New Jersey Health and Sanitary Association* will be held at Princeton on Friday and Saturday, December 10 and 11, 1937. The headquarters will be at Nassau Tavern on Palmer Square. The features of the program will be as follows:

FRIDAY MORNING

A choice of trips to:

1. Walker-Gordon Dairy in Plainsboro; or
2. Rockefeller Institute for Medical Research in Princeton; or
3. Sewage Disposal Plant and Incinerator in Princeton Bureau.

FRIDAY AFTERNOON LECTURES

1. Reducing Pneumonia Mortality—By Dr. Russell L. Cecil, New York City.

2. Early Diagnosis of Tuberculosis—By Dr. J. R. Morrow, Bergen Pines Hospital, Ridgewood, N. J.

3. Latent Tuberculosis—By Dr. Herbert R. Edwards, New York City.

4. A demonstration of what goes on at a mental hygiene clinic.

5. Motion pictures throughout the afternoon.

FRIDAY EVENING

Heart Disease, illustrated—By Dr. William D. Stroud, Philadelphia, Pa.

SATURDAY MORNING

A discussion of urgent health needs.

THE FASTEST LIVING THING

What is the fastest speed of a living thing that flies, or runs, or swims? This question is answered scientifically by Dr. Roy Chapman Andrews, Director of the American Museum of Natural History, New York City, in the October issue of its monthly magazine, "Natural History". Dr. Andrews has compiled a two-page chart of speeds which have been accurately determined by direct observation for a measured distance, or by the speedometer of a pursuing automobile, or by a graflex camera; and awards a citation for the greatest speed to a bot-fly, cephenomyia pratti, which infests deer of northern Mexico and resembles a bumble bee. Repeated estimates of the speed of flight with a graflex camera indicates that it attains a speed of 818 miles per hour, or 1200 feet per second. It is faster than the speed of a bullet shot from a service musket of the period of the American Revolution.

The following table shows the speeds of travel of typical animals and man-driven machines:

	Miles per Hour
Deer fly	818
Airplane	440
Duck hawk	180
Golden eagle	120
Railroad train	120
Swallow	110
Canvas back duck	72
Crow	60
Gazelle	60
Bobwhite	60
Greyhound	36
Flying fish, take-off	30
Man, ice-skating	22
Pike	10
Man in submarine	10
Red racer snake	3.6

The County Medical Societies have been responsive to the suggestion of the Advisory Committee on Cancer Control that they devote one meeting each year to the subject of cancer control. Bergen County seems to have been the first to carry out an extensive program. The meeting of December 6, 1936, was "Cancer Night", when the meeting was held in the Memorial Hospital, New York City, with the presentation of brief, snappy papers on scientific phases of the subject, which were published in the Journal of October, 1937, page 597.

Passaic County put on a "Cancer Week", October 12-15, which is reported on page 704 of this Journal.

This program was carried out with remarkable efficiency and interest.

The Union County Society is taking up the subject of a "Cancer Center", as described by Dr. A. R. Casilli on page 660 of this Journal.

The reports from these counties are valuable guides for other county societies who are planning programs in cancer control.

The subject of *sulphanilamide* was discussed in this Journal of August, 1937, page 505, in an article prepared under the auspices of the Joint Committee on Pharmaceutical Relations, setting forth the value of the drug in streptococcic infections. The next article in the same Journal was a case report of dangerous symptoms following the administration of the drug for gonorrhoea, and a warning issued by the Board of Pharmacy of New Jersey that "The promiscuous and unsupervised sale and use of the drug is contrary to the public interest." That this warning was justified is indicated by the reports of several deaths in Tulsa and St. Louis from the use of an elixir of the drug.

The A. M. A. Journal of November 8, 1937, page 1531, contains an exhaustive report of an investigation of the deaths and of the elixir. Every physician should read this report with care.

The A. M. A. Journal of November 6 also contains a report of a method of removing powder stains from the skin, written by a physician who himself was the patient. The method consists in softening the skin with hot, antiseptic compresses, and picking out the grains of powder one by one. The details of the method are simple, and can be carried out by any surgeon who is accustomed to doing delicate operations such as those on the eye.

The Committee on Public Relations, Dr. J. H. Kler, Chairman, has prepared a series of articles on medical subjects to be used as models of lectures by physicians to popular audiences. Dr. Kler has avoided both the technical and the commonplace, and has gone far toward giving medical explanations which are within the comprehension of intelligent laymen.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING METINGS

NOVEMBER, 1937

2	Camden	11	Passaic
2	Hudson	12	Atlantic
9	Bergen	17	Middlesex
10	Mercer (Banquet)	18	Gloucester
10	Ocean	18	Morris
11	Burlington	24	Monmouth
11	Essex		Sussex (at call of President)

DECEMBER, 1937

7	Hudson	10	Atlantic
7	Camden	10	Salem
8	Mercer	14	Bergen
8	Ocean	14	Cumberland
8	Union	15	Middlesex
9	Burlington	16	Gloucester
9	Essex	16	Morris
9	Passaic	22	Monmouth
9	Somerset		

ATLANTIC COUNTY

E. H. Nickman, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held October 10th, 1937, at the Ambassador Hotel, President H. S. Read presiding. There were fifty-five members and guests present.

SCIENTIFIC

The scientific program was presented by Dr. E. L. Eliason, Professor of Surgery, University of Pennsylvania, Philadelphia, Pa., whose subject was "Surgical Aspects of Indigestion."

The paper was briefly discussed by Drs. D. B. Allman and V. E. Johnson.

CONSTITUTION REVISION

Dr. Read reported that the Constitution Revision Committee had progressed in its work in taking up the changes to be made and consulting with the attorney on the incorporation of the Society.

A motion was made and passed that Chapter 5, Section 5, of the By-Laws be stricken out and the following revision inserted in its place: "The fiscal year of this Society shall be from May first to April thirtieth inclusive."

NEW BUSINESS

A letter was read from Dr. H. L. Harley, Chairman of the Medical Economics Committee, referring to a communication from the Visiting Nurses' Association regarding having a member of this society volunteer to work one Sunday during the year to relieve the present city physicians who "need the week-ends for rest." A motion was made and passed that Dr. Harley's letter be received and filed.

An invitation was extended to all members to attend the Testimonial Dinner to be given in honor of John R. Hollinger on Saturday evening, October 11, at the Madison Hotel.

A request from the Atlantic City Medical Association for an appointee to the Baby Keep-Well Station on the Northside was read. This was referred to the Public Relations Committee for action.

Three applications for membership from Dr. A. M. Rechtman, Dr. C. K. Murray and Dr. I. C. Shavelson were referred to the Board of Censors.

A report from Dr. L. A. Wilson, Chairman of the Advisory Committee to the Auxiliary, was read.

A motion was made and passed that the proper resolutions be prepared on the death of Dr. Clarence Garrabrandt, and a moment of silence was observed in his memory. Dr. W. J. Carrington was appointed to draft these resolutions.

BERGEN COUNTY

LeRoy W. Black, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held at the Holy Name Hospital, Teaneck, on Tuesday, September 14th, with Dr. C. A. King, Vice-President, presiding in place of Dr. Charles Littwin, our President. Dr. King read a telegram from Dr. Littwin regretting his absence and wishing the society good luck for the coming year.

Dr. G. B. Barlow explained the printing of the lectures of the post-graduate course in 1937, on endocrinology, and offered the remaining pamphlets for sale at $1.00 each.

The Secretary read a communication from Dr. Joseph H. Kler, Chairman of the Sub-Committee on Public Relations of The Medical Society of New Jersey. Dr. Kler urged us to publicize the "Cancer Week" symposium sponsored by the Passaic County Medical Society, beginning the week of October 11th, 1937.

NEW MEMBERS

The following were elected to membership:

From Junior to Regular—
Dr. Lee Solworth, Englewood

To Junior—
Dr. Isabel B. Turner, Englewood
Dr. Donald A. Richter, Englewood
Dr. Osborne F. Christensen, Hasbrouck Heights

The following applications for membership were read:

From Junior to Regular—
Dr. Joseph D. Gatti, Hackensack
Dr. Donald J. Kissinger, Dumont
Dr. John Scillieri, Hackensack
Dr. Frank L. Lombardi, Teaneck
Dr. Robert R. Grimes, Teaneck

To Regular—
Dr. John P. Mohair, Maywood

To Junior—
Dr. Henry E. Prall, Cliffside Park
Dr. Francis I. Tomlins, Ridgewood

SCIENTIFIC PROGRAM

Dr. Walter J. Farr introduced Dr. Earl W. Fuller, Director of Northern New Jersey Mental Hygiene Clinic, Greystone Park, New Jersey. Dr. Fuller recited many very interesting cases illustrating:

1. Neurosthenia;
2. Behavior problems; and
3. Organic problems, seemingly nervous in origin.

He emphasized the importance of proper consideration of the fears and worries of the hospital patient which were brought out by thoughtless procedures or comments of doctors, nurses, and attendants.

Judge Thomas L. Zimmerman, former Judge of the Court of Domestic Relations and Juvenile Delinquency, commented upon Dr. Fuller's remarks, stressing the necessity of close coöperation between the court, and the psychiatrist and psychiatric workers. Drs. G. M. Knowles, E. N. Huff, G. Winter, G. C. H. Burns, and W. J. Farr took part in the discussion.

October Meeting

The regular meeting of the *Bergen County Medical Society* was held at the Hackensack Hospital on Tuesday, October 12th. Dr. Littwin, our President, presided.

PUBLIC RELATIONS

The public relations program of speakers and subjects was mentioned, and members were asked to volunteer as speakers. Dr. Littwin urged that each member write an article on some health topic to be used for a later public relations project or address.

COMMUNICATIONS

1. A letter from Dr. E. Zeh Hawkes, first vice-president of the State Society, requesting that he be assigned on the program of the meeting on November 9th, to present the program of the State Society.

2. A letter from Mr. C. H. Gilman, manager of the Ideal Farms, inviting our members to inspect the farms in Augusta, New Jersey, on October 27th or 28th. Upon motion it was decided to accept this invitation for Wednesday, October 27th. The executive secretary is to send post cards to the members giving specific information.

NEW BUSINESS

Our president announced that Dr. Victor A. Blenkle was unable to continue as chairman of the Public Health Committee and appointed Dr. S. I. Franklin in his place.

Dr. Littwin announced that Dr. L. A. Markley had resigned as treasurer of the Society because of ill health, and suggested that Dr. W. K. Harryman be made treasurer. There was no objection and Dr. Harryman was appointed.

The President announced that the November meeting would be held at the Bergen Pines Hospital, and that the Rockland County Medical Society had accepted our invitation to attend.

Dr. F. J. Vita, Chairman of the Entertainment Committee, announced that the plans had been completed for the annual dinner at the Swiss Chalet on November 18th.

NEW MEMBERS

The following members were elected:

From Junior to Regular Membership: Dr. Joseph D. Gatti, Hackensack; Dr. Donald J. Kissinger, Dumont; Dr. Robert R. Grimes, Teaneck.

To Regular: Dr. Francis O. Osterhus, West Norwood.

To Junior: Dr. Henry E. Prall, Cliffside Park; Dr. Francis I. Tomlins, Ridgewood.

Applications for membership were received from seven physicians.

MEDICAL-DENTAL SERVICE BUREAU

Mr. J. S. Kinne, Executive Director, Medical-Dental Service Bureau of the Bergen-Passaic Counties, explained to us how the bureau was aiding the doctors.

SCIENTIFIC

Dr. Charles Murray Gratz, F. A. C. B., Associate in Orthopedic Surgery, Columbia University, and Assistant Attending in Orthopedic Surgery, Post-Graduate Hospital, gave a very interesting talk, illustrated by lantern slides, upon "Fascial Adhesions as a Cause of Pain." He brought out new points of view in emphasizing the fact that fascial spaces between the muscles acted as joints and the fasciae as serous surfaces. The fasciae are very strong, and their strength is cut down by shearing forces and by trauma.

Henry H. Kessler, M.D., F. A. C. S., Director of New Jersey State Rehabilitation Clinic, Newark, New Jersey, spoke upon "Cineplastic Surgery", which was very well demonstrated by a talking movie, illustrating the surgical technic and the end results. Two patients with artificial arms were present. One played a violin.

Meeting adjourned.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

The regular bi-monthly meeting of the *Cumberland County Medical Society* was held in the Vineland Training School on Tuesday afternoon, October 13, with President Leslie E. Myatt presiding.

A social meeting in the near future was proposed by Dr. Muriel Ramsey, of Millville.

TUBERCULOSIS TESTING

Dr. Charles Butcher, of Heislerville, introduced the subject of testing high school students for tuberculosis by means of the tuberculin injections and the x-ray. Dr. E. C. Knight, District State Health Officer, descried the method and the good results attained in the larger centers where the plan had been carried out thoroughly. (See Journal, October, 1937, p. 637.) No definite action was taken.

NEW MEMBER

Dr. Clifford Baker, Vineland, was elected a member of the Society.

SCIENTIFIC

Dr. Joseph B. Wolffe, Associate Professor of Medicine, Temple University, was the guest speaker. His subject was "Newer Treatments of Angina Pectoris and Arteriosclerosis", illustrated with lantern slides.

Dinner was served in the Administration Building.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

President H. Roy Van Ness of the *Essex County Medical Society* presided at his first meeting of that body Thursday evening, October 14, 1937, at the Academy of Medicine, Newark. He had arranged a program of timely subjects.

COMMITTEE REPORTS

Dr. Chester R. Brown, of Arlington, chairman of the newly created child welfare committee, surveyed some of its purposes and problems.

Dr. Richard H. Dieffenbach, chairman of the lung committee, gave a practical exposition of the current understanding of empyema, its diagnosis and treatment.

TRAINING FOR NURSING ATTENDANTS

Clara H. Krauter, B. S., principal of the Essex County Girls' Vocational School, 300 North Thirteenth Street, Newark, N. J., describing the newly instituted "Training for Nursing Attendants" in her vocational school, was the feature of the evening.

This part of the program had been arranged and sponsored by Dr. A. Charles Zehnder, Chairman of the State Committee on Nursing and Nursing Education, who said:

"There is a definite field and an urgent need for a nursing attendant to minister to the physical wants of the mildly sick, the post-operative home patient, the mother and new-born infant, the patient who is not seriously ill, and the aged. To supply this need, women between the ages of 21 and 45 years, and whose minimum of education is that of a grammar school, should be trained.

"This special field of nursing should include simple nursing procedure, plain housework, cooking, and care of the well child. In other words, in addition to caring for the patient, the nursing attendant should be trained to manage a home in which there is no servant, or very little service.

"The salary for such assistance should be about $18.00 to $21.00 per week.

"Over 90 per cent of the medical profession interrogated had expressed a need for and a willingness to employ these nursing attendants."

Miss Krauter said that the girls trained in the courses at her vocational school were designated by several different terms, as "Home Nursing Aids", "Nursing Attendants", "Nursing Assistants", "Aids in Nursing", "Subsidiary Nurses", etc. The inauguration of this course of training had resulted from a public demand,—first on the part of the people who need efficient assistance in the home in the care of the sick but who find the trained nurses or graduated nurses unsatisfactory for various reasons. There has been shown to be a great demand for competent assistance with the sick in the home by others than graduate nurses.

The second demand for this type of training came from young women who desired to receive training in the care of the sick, but who could not afford the cost of hospital training, or of the time required, or meet the educational entrance requirements of the hospitals. The inauguration of the course was recommended by the State Society's Committee on Nursing Training. An advisory committee composed of physicians, nurses, and lay women coöperates with the vocational school. The chief instructor is a registered nurse who is experienced in nursing work in the home. The girls are trained in home nursing procedures, and also in the management of the home. They should be valuable assistants in the care of the sick in a home where there is not serious illness. The course extends over ten months, and in its latter part embraces practical experience with patients.

Funds for the inauguration of this new educational project are part of fourteen million dollars set aside by the Federal Government for this purpose.

The purpose of this course is to train young women for positions in homes requiring an assistant who can manage and operate the home and aid in the care of a patient. It trains for care of the convalescent, the patient who is not seriously ill, the aged, children, and the infant.

Courses began September 8, 1937. Students may enter any time after that date if there is space in the class.

Cost: There is no tuition charge for residents of Essex County, as the school is supported by taxation. For non-residents, a tuition fee of $15.00 a months is charged. Non-residents will be accepted only after all applicants from Essex County have been cared for.

All materials used in instruction are furnished free to the pupils, but students must supply their own uniforms and personal equipment as required.

Entrance Requirements: The applicant must be at least seventeen years of age, and have completed two years of vocational or high school. Applicants must also meet the health and personality standards set by the Advisory Committee.

Length of Course: It will take the average student about ten months to complete all the work offered. The school hours are from 8:45 a.m. to 3:30 p.m. The hours will be adjusted to the indi-

vidual case when practical experience in homes and institutions is arranged. The course includes:

Personal—Hygiene and professional ethics.

Elementary physiology and anatomy.

Sterilization.

Home nursing procedures.

First aid.

Dietetics—Study of food values; plan meals for family, infants, children, adults and aged; plan meals from diet lists given by the doctor.

Order, prepare and serve—Family meals, trays for normal diet, trays for special diet, infant's food.

Care of the well infant and children.

Care of aged.

Household management.

Entertainment of patient.

Practice in homes, institutions, and day nurseries.

Dr. Edgar A. Ill, who has long been interested in the training of nurses, tried, when he was a member of the Newark Board of Education, to inaugurate courses in the public school system to teach the basic sciences of nursing and the didactic portion of nursing training. Dr. Ill enthusiastically endorsed this new project, urged the coöperation of the nursing and medical profession, suggested that we encourage the enrollment of more students and moved that the Essex County Medical Society go on record as approving this school, the type of training and urging its continuance. The motion was passed unanimously.

The following new members were elected: Harold W. Brown, Montclair; Leonard P. Burke, Verona; John Stoughton Cregar, East Orange; Noah Feldman, Newark; Jacob Flax, Newark; Joseph Phelps, Caldwell; Morris E. Streen, Newark.

Associate—Arthur Bernstein, Newark; Frederick C. DeTroia, Newark; William Ehrlich, Newark; Walter W. Gilligan, Nutley; Frank Giuffra, Montclair; Jerome Goldman, Newark; Melvin A. Greer, Bloomfield; Elinor Eastman Hadley, Maplewood; John J. Kobes, Kearny; Morris Harold Kreeger, Bloomfield; Thomas Messina, Newark; Saverio Monaco, Newark; Paul Anthony O'Connor, Newark; Salvador Pentecost, Bloomfield; Nathan H. Ram, Caldwell; Seth D. Revere, East Orange; George A. Schiller, Newark; Harry Taff, Newark; David M. Wayne, Newark; John Anthony Zingali, Montclair.

Transfers—Everett W. Probst, Rutherford; William H. Seward, Orange.

Academy of Medicine of Northern New Jersey

Reported by Franklin J. Tobey, M.D., Secretary

A stated meeting of the *Academy of Medicine of Northern New Jersey* was held in its building at 91 Lincoln Park, Newark, with Vice-President Charles M. Robbins, presiding.

Dr. Ray T. Munger, Plainfield; Robert R. White, East Orange, and Clement E. Schotland, Newark, were elected to membership.

The program of the evening was under the auspices of the Committee on Public Health and Medical Education, whose personnel is as follows:

Max Danzis, M.D., Chairman, Newark
J. Irving Fort, M.D., Newark
Bernard Greenfield, M.D., Newark
Henry B. Kessler, M.D., Newark
Henry B. Orton, M.D., Newark
Aaron E. Parsonnet, M.D., Newark
Charles M. Robbins, M.D., Newark
Earl H. Snavley, M.D., Newark
A. Charles Zehnder, M.D., Newark
Charles F. Rathgeber, M.D., East Orange
Christopher A. Brokaw, M.D., Elizabeth
Frank A. Bien, M.D., Irvington
Abraham E. Jaffin, M.D., Jersey City
Oscar A. Mockridge, M.D., Montclair

Dr. Danzis welcomed the large audience which had assembled to hear a popular address by Dr. Clements C. Fry, Associate Professor of Psychiatry and Mental Hygiene, Yale University School of Medicine. The subject of Dr. Fry's paper was "Personality Types and Their Relation to Mental Hygiene". The address was of a type which is of practical value to the family doctor.

The next stated meeting will be held on November 18, when Dr. William P. Murphy, Harvard University, will give an address on "Pernicious Anemia".

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The regular monthly meeting of the *Gloucester County Medical Society*, combined with the Annual Banquet and Ladies' Night, was held on the evening of Thursday, October 21, 1937, in The Homestead, Woodbury. There were present twenty-seven physicians, nineteen ladies, and six guests. The President of the society, Dr. Oran Wood, of Paulsboro, presided, and introduced the representatives from The Medical Society of New Jersey, who gave brief addresses.

Dr. W. J. Carrington, Atlantic City, President-Elect of the State Society, outlined four major activities of the Society:

1. The preservation of the private practice of medicine.
2. Cancer control.
3. A workable medical practice act.
4. Improved relations between hospitals and physicians.

Dr. LeRoy A. Wilkes, Executive Officer, spoke on the mutual relationship and dependency between the State Society and every county organization. The resources of the Executive Offices are at the disposal of the local societies, and are being used to an increasing extent.

Dr. Frank Overton, Editor of The Journal, showed the volume of State Society Transactions of 1899, containing a sixty-three-page account of the meeting of the Gloucester County Medical Society on September 15, 1898, in celebration of the eightieth anniversary of the founding of the society in December, 1818. The article had a photograph of the members of the Society in 1898. These were identified by Dr. H. B. Diverty and others. Compare the photographs of Drs. Diverty, Palm, and Hillegas on the next page with their portraits taken thirty-nine years later which are printed on pages 355 and 356 of The Journal of May, 1937. Drs. Brewer, Fisler, and Gifford are also still living.

Dr. Chester I. Ulmer announced the award of the Society's medal for "Valor or Achievement" of a member during the past year. (See Journal, December, 1936, page 731.) The medal this year was awarded to Dr. Dorothy Rogers, of Woodbury, for her loyalty to the Gloucester County Medical Society.

The entertainment was most pleasing, and the entertainers were well known to many of the physicians, and included the following:

1. Areari and his accordion.
2. Gustav Bohn, magician, with his mystifying feats of mind reading.
3. Grant Gardner, with his ukelele and bells, and his singing daughter Elleen.
4. Robert Taylor and his orchestra.



THE GLOUCESTER COUNTY MEDICAL SOCIETY AT THE EIGHTIETH ANNIVERSARY OF ITS FOUNDING, SEPTEMBER 15, 1898

From the Transactions of The Medical Society of New Jersey of 1899, page 331

Drs. Diverty, Hillegas, Brewer, Fisler, Palm, and Gifford are still living

The following key to the identity of the physicians was supplied by Dr. Henry B. Diverty:

1. James Hunter, Jr., Westville
2. Harry A. Stout, Wenonah
3. George E. Reading, Sec. and Treas., Woodbury
4. George C. Laws, President, Paulsboro
5. Charles S. Heritage, Vice-President, Woodbury
6. Samuel F. Stanger, Harrisonville
7. Eugene Z. Hillegass, Mantua
8. Howard A. Wilson, Woodbury
9. Henry B. Diverty, Woodbury
10. Luther M. Halsey, Censor, Williamstown
11. William Brewer, Woodbury
12. William H. Iszard, Honorary Member, Camden
13. Eugene T. Oliphant, Bridgeport
14. J. Grant Edwards, Williamstown
15. P. E. Stilwagon, Bridgeport
16. Joseph M. Husted, Clayton
17. David H. Oliver, Bridgeton
18. George W. Bailey, Wenonah
19. Frank Fisler, Clayton
20. Howard F. Palm, Camden
21. William A. Stratton, Woodbury
22. Matthew Elmer, Bridgeton
23. Cyrus B. Phillips, Hurffville
24. John J. Kromer, Honorary, Philadelphia
25. T. Franklin Gifford, Dentist, Woodbury
26. Samuel F. Ashcraft, Mullica Hill

HUDSON COUNTY

At a regular meeting of the *Hudson County Medical Society* held on May 4, 1937, in the Carteret Club, Jersey City, the following resolution was introduced by Dr. T. J. Schmuck, and was adopted:

Whereas, the protest by a small minority of the Hudson County Medical Society of the election held in October, 1936, has led to a great deal of controversy and misunderstanding among the members of our society, and

Whereas, the elected officers of the Hudson County Medical Society, including the President, Secretary, the Executive Committee, Nominating Committee, and Election Committee, who held office during the years 1935 and 1936, were by implication accused of neglect of duty and unfair and unethical practices; and

Whereas, the Judicial Council of The Medical Society of New Jersey supported the protestants in their claims and accusations; and

Whereas, the House of Delegates of The Medical Society of New Jersey at its Annual Meeting in June, 1936, refused to give a hearing to the appeal of the majority of the Hudson County Medical society; and

Whereas, this sequence of events gave rise to a great deal of undesirable publicity in the daily press, and tended to undermine the high standing of the medical profession in this county in the eyes of the laity; and

Whereas, through the able and efficient presentation of the case of the majority before the Judicial Council of the American Medical Association by Drs. Brennock and Norton, the Council exonerated the officers of this society from any suspicion of improper and unethical action, and emphasized the irregular and unconstitutional methods of the Judicial Council of The Medical Society of New Jersey, the House of Delegates and the Board of Trustees; and

Whereas, through this final and emphatic action of the Judicial Council of the American Medical Association the good name of the Hudson County Medical Society, its officers and membership has been completely reëstablished; therefore be it

Resolved, that the Hudson County Medical Society at its annual meeting assembled extend its highest appreciation and sincerest gratitude to Dr. Thomas McG. Brennock, Dr. James F. Norton, and Dr. J. L. Evans, through whose untiring efforts this vindication of the Hudson County Medical Society has been accomplished; and be it further

Resolved, that, in order to acquaint the entire membership of our society as well as that of the other counties of this State, of the debt of gratitude which this society owes to Dr. Thomas McG. Brennock, Dr. James F. Norton, and Dr. J. L. Evans, this resolution be printed in full in the Bulletin of this society, and a copy of the same be sent to the Secretary of The Medical Society of New Jersey, and to the Editor of the State Journal for publication.

October Meeting

A regular meeting of the *Hudson County Medical Society* was held on Tuesday, October 5, 1937, at the Carteret Club, with the President, Dr. W. L. Williamson, of Bayonne, presiding.

SCIENTIFIC

Dr. Williamson introduced Dr. Arthur W. Masters, Cardiographer at Mount Sinai Hospital, New York, who spoke on the subject "Prognostic Factors in Coronary Thrombosis". The address was discussed by Drs. Jaffin, White, Pearlstein, Dodson, Leir, Arbeit, Rosecrans.

The report of the Executive Committee as printed in the society's Bulletin was approved.

MEMORIAL TO DR. BLASE COLE

The following resolution, offered by Dr. Joseph F. Londrigan, was adopted:

"The Hudson County Medical Society having learned with feelings of deep regret the news of the sudden death of Dr. Blase Cole, of Newton, a member of the Board of Trustees of The Medical Society of the State of New Jersey, as unanimously

"Resolved to convey to his widow and to the Board of The Medical Society of New Jersey its heartfelt sympathy on the loss of so distinguished a member of its organization and a physician of such high repute."

SYPHILIS SYMPOSIUM

Dr. Claudio E. McNenney, Chief of the Division of Communicable Disesaes, Health Bureau, Jersey City, extends a cordial invitation to the members of the Hudson County Medical Society to attend a symposium on syphilis at the Nurses' Home, Medical Center, Jersey City, at 4:30 p.m., Friday, October 8th. There will also be shown a motion picture entitled "Syphilis" and (1) its nature, (2) its prevention, (3) its treatment. Dr. Edmond J. Daly will preside.

PUBLIC HEALTH COMMITTEE

Dr. A. E. Jaffin spoke on an enlargement of the membership of the Public Health Committee. The plan proposed by the committee itself is that the present membership of nine should be doubled, and that Jersey City should have a representation of six members; Bayonne, two; Kearny and Harrison, two; Hoboken, two; North Hudson, including Union City, Weehawken, West New York, North Bergen, Woodcliff, Secaucus, Guttenberg, six. The plan was referred to the Executive Committee.

The following resolution offered by Dr. J. F. Londrigan was adopted:

Whereas, due to the tragic and untimely death of Dr. Blase Cole, of Newton, a member of the Board of Trustees and The Medical Society of New Jersey, there now exists a vacancy on the Board of Trustees for the Second Judicial District, and

Whereas, the Hudson County Medical Society is one of the component societies in the Second Judicial District, and incidentally, the second largest component society in the entire State, and

Whereas, the representation of the Hudson County Medical Society on the Board of Trustees, as it is now constituted, is thought to be grossly inadequate,

Now therefore, be it resolved, that the Hudson County Medical Society, in regular meeting assembled on October 5, 1937, calls to the attention of the Board of Trustees of The Medical Society of New Jersey these foregoing facts, and requests that the aims, needs, and sympathies of the Hudson County Medical Society be recognized by appointing one of its members to the vacancy now existing in the Second Judicial District, such member to be acceptable to the Hudson County Medical Society, and

Be it further resolved, that a copy of this resolution be sent immediately to each member of the Board of Trustees of The Medical Society of New Jersey.

NEW MEMBERS

The following new members were elected:

Dr. Louis E. Norwich, 355 Avenue C, Bayonne
Dr. John Vaccaro, 130 West 55th Street, Bayonne

Meeting adjourned 11 p. m.

MERCER COUNTY

A. D. Hutchinson, M.D., Reporter

The *Mercer County Medical Society* held its regular monthly meeting in the Trenton Country Club on October 13, with President D'Arcy presiding.

SCIENTIFIC

Dr. Edward F. Roberts, the guest speaker, gave an address on the serum treatment of pneumonia, based on the experience of the Staff of Harlem Hospital, New York City. With the aid of lantern slides and moving pictures, Dr. Roberts described the methods of determining the type of pneumococcus present in the sputum, the methods of typing, the mode of administration of the proper serum, and the method of testing the allergic susceptibility of the patient before the serum is given.

EXECUTIVE COMMITTEE

The Executive Committee gave its report and made the following recommendations:

1. The fiscal year of the county society be that of the State Society.
2. Elect a President-Elect one year before he assumes office. The Society voted to appoint a committee to prepare an amendment to the Constitution and By-Laws in order to carry out the proposal.
3. Visiting delegates to other county societies be appointed. This proposal was adopted. Drs. A. Guy Campo and Ralph C. Venturo, representatives of the Gloucester County Medical Society, being present, were invited to sit with the society and take part in the discussions.
4. Post-graduate courses be arranged at once. Dr. E. F. Purcell, Chairman of the Post-Graduate Committee, stated that interest in the courses had greatly increased during the past three years.
5. A meeting of the county societies of the Third District be arranged with the District Councilor. A committee on the meeting was appointed.
6. A recommendation that a committee on revision of the Constitution and By-Laws be appointed was adopted.
7. The society also adopted a recommendation that the Mercer County Medical Society be listed in the telephone directory.

PUBLIC RELATIONS COMMITTEE

Dr. Wilbur Watts, Chairman of the Public Relations Committee, reported:

1. An enlarged report of the Speakers' Bureau had been received.
2. A study of Baby Keep-Well Stations was progressing, and a list of nominations for clinic physicians would be prepared.

NEW MEMBERS

Drs. T. R. Siemion and L. S. Snegireff, both of Trenton, were elected Associate Members.

Eight proposals for membership were referred to the Membership Committee.

ANTI-TUBERCULOSIS CAMPAIGN

Dr. J. F. Pessel called attention to the need of more activity by the society in anti-tuberculosis work. He was supported by Drs. Watts, Williams, Sica, Pierson, Haggerty, and Proctor. On motion, the Society voted to establish a Committee on Tuberculosis. Dr. Pessel was appointed its chairman.

MIDDLESEX COUNTY

Charles H. Calvin, M.D., Reporter

President John H. Rowland, M.D., presided at the regular monthly meeting of the *Middlesex County Medical Society* at The Pines, Wednesday evening, October 20, 1937, with approximately ninety members present.

ADDRESS BY PRESIDENT HERRMAN

William G. Herrman, M.D., Asbury Park, President of The Medical Society of New Jersey, gave an address on the subject "Objectives of a County Medical Society".

NEW MEMBERS

Dr. Malcolm Dunham, Woodbridge, N. J., and Dr. W. A. Balogh, Dunellen, N. J., were elected to Associate Membership.

COMMITTEE ON CONTRACT PRACTICE

Dr. A. F. Donlon, Chairman, asked for expression regarding contract practice from individual members. A lively discussion as to what is meant by undesirable contract practice was entered into by Drs. Fishkoff, McGoern, Rothchild, Haywood, and Saulsberry.

COMMITTEE ON CHILD HEALTH

Dr. J. S. Uhr, Chairman, stated the recommendations approved during June meeting will be carried out at a later date. This provided for a Health Day, a radio address, a conference with the Woman's Auxiliary, and a mass meeting of Parent-Teachers Associations to acquaint the public on preventive measures for all school and pre-school children.

RELIEF AND MUNICIPAL PATIENTS

On July 15th New Brunswick, which is the only city in Middlesex County where the old relief plan is not in operation, and medical care is not furnished by the City Physician and through clinics, held a meeting in which the medical care of relief and municipal patients were discussed. The following resolution was sent to the City Commissioners:

"The doctors of New Brunswick propose that a plan be adopted whereby physicians shall receive remuneration for the medical care of municipal and relief cases; and that this plan shall be similar to that under the old relief set-up as is in practice in other communities in the county."

A letter in reply from Commissioner Dwyer was read in which he stated he will coöperate as far as possible.

COMMITTEE ON TUBERCULOSIS

Dr. C. I. Silk, chairman, read the following resolutions passed by the Middlesex County Tuberculosis League and asked that they be approved by the Medical Society:

"1. The Middlesex County Tuberculosis League passed a resolution asking the Middlesex County Medical Society to recommend a policy for nominating physicians to do the tuberculin testing and x-raying of high-school-age children.

"2. The Board of Directors of the Middlesex Tuberculosis League recommended to the Middlesex County Medical Society that school personnel and bus drivers be included in the tuberculin testing and x-raying program, at a cost not to exceed $1.25 per person."

The two resolutions were discussed by many members with the following results: With reference to Resolution number one—A motion was made by Dr. Haywood and seconded "that the appointing of physicians for the tuberculin testing of high-school-age children be referred to an appointed committee, and this committee to report at the next meeting". This was passed.

Resolution number two was disapproved.

X-raying of those children who have positive findings, on paper films, was referred to a special committee which shall be appointed and to report at the next meeting.

COMMITTEE ON INSURANCE

Dr. R. J. Faulkingham, chairman, read a letter from the Commercial Casualty Company of Newark on insurance for members of the Medical Society.

MEETING HALL

It was moved and seconded that the Society dispense with meals after monthly meetings, and pay $10.00 per month for the use of the hall at The Pines. This was passed.

MEETING WITH DENTISTS

A letter from the Middlesex County Dental Society was read asking for a joint meeting at least once a year. This was referred to a special committee.

FEES FOR TREATING PENSIONERS

A letter from Mr. Wyckoff was read concerning the payment of doctors' fees for pensioners, etc. The secretary was instructed to reply to the letter.

MEDICAL FILMS

The following companies offer medical films for our approval which can be obtained free:

Mead Johnson & Company—"The Birth of a Baby".
Eli Lilly & Company—"Collapse Therapy", "Ergoticin", "Amebiases", "Control of Pertussis".

This was referred to the proper committee.

EXAMINATION OF BEAUTICIANS

It was moved and seconded that the State Board of Beauticians be approached by an appointed committee to recommend that either a complete physical examination be required, or that the superficial one, in which all licensees have a card stating they are free from any communicable skin disease and signed by a physician, be abolished entirely.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A combined business and clinical meeting of the *Morris County Medical Society* was held the evening of October 21st at the Dover General Hospital. President L. E. Williams opened the meeting with approximately fifty present.

EXECUTIVE COMMITTEE

The Executive Committee reported its meetings of September 7 and October 10, which included the following items:

a. Program of meetings for the current fiscal year as appearing in the Bulletin:

October—Dover Hospital, clinical meeting
November—Non-scientific speaker
January—All Souls' Hospital, clinical meeting
February—Memorial Hospital, clinical meeting
March—Non-scientific speaker
May—Greystone Park, clinical meeting
June—Annual Meeting

b. Appointment of Drs. Havens and Larson to prepare an obituary of the late Dr. L. L. Mial, for the State Journal. (See page 706.)

c. Coöperation with the Morris County Credit Bureau for the collection of bills, and the appearance at this meeting of representatives of the Credit Bureau.

d. Resignation of Dr. H. H. Larson as Vice-President, which was accepted with regret.

CREDIT BUREAU

Representatives of the Morris County Credit Bureau addressed the meeting, outlining the benefits of increased coöperation, and action was unanimously taken that President Williams appoint a committee to confer with the representatives of the Credit Bureau, and to report at a later meeting.

SCIENTIFIC

At this point, the President turned the meeting over to Dr. King, of the Dover General Hospital Staff, for the scientific chapter. This consisted of informal presentation with x-rays of several cases of compressed fractures of the vertebrae, followed by some unusual cases such as a bilateral tumor of the kidney in a one-year-old child. Presentations were by Drs. Baker, Carberry, Ackerman, and King. Interesting discussions followed.

After a very interesting session, buffet refreshments were served.

Neuro-Psychiatric Association Meeting

A monthly meeting of the *Northern New Jersey Neuro-Psychiatric Association* was held at the New Jersey State Hospital at Greystone Park the evening of Wednesday, October 27, President C. C. Beling, M.D., presiding.

The scientific chapter consisted of presentation of papers and patients by members of the hospital staff, as follows:

1. Cases of Syphilis of the Central Nervous System, with negative laboratory reports, which responded to malarial treatment; presentation by Dr. Thomas G. Peacock.

2. Some Experiences with Insulin Therapy in Cases of Dementia Precox; presentation by Dr. Carl M. Sagert.

3. Some Autonomic Aspects of Personality Disorders; by Dr. Malcolm C. Taylor.

4. Outline of the Work of the Mental Hygiene Clinics of Northern New Jersey; by Dr. Theodore Gebirtig, Assistant to the Director of Mental Hygiene Clinics operated from the Greystone Park Hospital.

5. Foreign Bodies Swallowed by Psychotic Patients; by Dr. Edward Kessler.

Interesting discussions followed the presentations and much interest was manifested in the results of insulin therapy in cases of dementia precox.

Refreshments were served in the hospital cafeteria.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held in the Central High School, Paterson, on the evenings of Wednesday and Friday, October 13 and 15, as a part of the program of "Cancer Week", sponsored and managed by the society.

LECTURES TO PHYSICIANS

On Wednesday evening, October 15, the scientific program was as follows:

1. Introductory Remarks,—Dr. William G. Herrman, Asbury Park, President of The Medical Society of New Jersey. Dr. Herrman reviewed the facilities available in Passaic County for the diagnosis and treatment of cancer.

2. Pathology of Cancer of the Stomach—Dr. Fred T. Stewart, Pathologist, Memorial Hospital, New York City.

3. X-Ray Diagnosis of Cancer of the Stomach—Dr. Ralph Herendeen, Roentgenologist, Memorial Hospital, New York City.

4. Treatment of Cancer of the Stomach—Dr. George T. Pack, Attending Surgeon, Memorial Hospital, New York City. The lecture was illustrated with lantern slides.

The scientific program of the society at its meeting on October 15 was as follows:

1. Pathology of Growths of the Colon—Dr. Paul Klemperer, Pathologist, Mount Sinai Hospital, New York City.

2. X-Ray Diagnosis and Irradiation Therapy of Growths of the Colon and Rectum—Dr. John T. Farrell, Jr., Roentgenologist, Jefferson Medical College Hospital, Philadelphia, Pa.

3. Surgical Treatment of Cancer of the Colon and Rectum—Dr. R. Cattell, Lahey Clinic, Boston, Mass.

All three lectures were illustrated with lantern slides.

ROUND-TABLE DISCUSSIONS

Round-table discussions by physicians were held in the Paterson Free Library at 4 o'clock on Tuesday, October 12:

1. On Cancer of the Stomach, led by Dr. Norman M. Dingman, Paterson.

2. On Cancer of the Colon, led by Dr. William Spickers, Paterson, on Thursday, October 14.

MEDICAL EXHIBIT

A medical exhibit for physicians was open every afternoon, covering pathology, surgery, radiation, statistics, and other scientific phases of the cancer problem. The exhibits were contributed by the various hospitals of the county: Paterson General, St. Joseph's, Barnert Memorial of Paterson, Passaic General, St. Mary's, and Beth Israel of Passaic.

Short resumes of cases and x-ray films gave excellent descriptions of cancer of the stomach and colon. There were pathological specimens shown. This exhibit covered the hall and a large room in the Paterson Library. It is estimated that over 2,000 people visited these exhibits.

POPULAR EXHIBITS

An exhibit for the public was also held every afternoon from 2 to 6 o'clock.

A sound film was shown on every afternoon at 2 o'clock on the subject "Conquering Cancer". This film depicted the methods of research in the laboratory on mice and other animals, and the clinical procedures in diagnosing and treating cancer. This film was the one produced by "March of Time" under auspices of leaders in the medical profession. The hall contained only eighty seats and at least 100 saw the movie at each of the five afternoon sessions. It was received by the audience with deep interest.

POPULAR LECTURES

Lectures to the public were given with the following program:

1. Popular Publicity Regarding Cancer—By Dr. Joseph H. Kler, New Brunswick, Chairman of the Public Relations Committee of The Medical Society of New Jersey.

2. Dr. Samuel Ginsburg, Passaic, gave a popular address on the "Responsibility of the Public in the Cancer Problem", emphasizing the need of the cooperation of the people in submitting to tests during the early stages of cancer. He showed that laboratory and x-ray facilities are now available as compared with their lack a few years ago; and spoke of the value of an annual physical examination in detecting the early signs of cancer when the condition is curable.

3. "The Truth About How 145,000 Americans Lost Their Lives During the Past Year" was the subject of a popular talk by Dr. Frank E. Adair, Attending Surgeon, Memorial Hospital, New York City.

LECTURES FOR NURSES

Lectures for nurses were given on Monday and Wednesday afternoons at 4 o'clock:

1. Dr. William Spickers, Paterson, addressed the nurses on "The Care of the Cancer Patient", and had to repeat his lecture on an overflow audience of nurses.

2. Dr. A. J. Delario, of the Tumor Clinic of St. Joseph's Hospital, Paterson, spoke on the subject "Cancer is Curable". He described the effect of the x-ray in destroying the chemical substance which seems to be associated with cancer; and said that a study of 51,000 cases showed that 25 per cent of advanced cases had been cured, and 75 per cent of the early cases.

3. Dr. Sigurd W. Johnsen, Passaic, gave a popular address on the subject "The Fear of Cancer".

4. Dr. L. G. Shapiro spoke on the subject "The Nurse and the Cancer Problem".

5. Dr. James S. Gallo, Paterson, gave an address on "The Danger Signals of Cancer".

A major object of the Cancer Week was to interest the people of Passaic County in the subject of cancer. At a conservative estimate of at least 3000 persons attended the exhibits and popular lectures.

The daily newspapers of Paterson and Passaic were generous of their space, devoting more than 120 inches to the meetings during the week. Their articles were well prepared and clearly expressed, and reflected credit on the reporters who wrote the stories, and Dr. Shapiro, Chairman of the Cancer Control Committee, who supplied them with information.

UNION COUNTY

Summit Medical Society

Reported by E. H. Macpherson, M.D., Secretary

The *Summit Medical Society* held the first meeting of the season on Tuesday evening, September 28th, at the Nurses' Home of Overlook Hospital in Summit.

Dr. Dengler, the Health Officer of Summit, outlined a campaign against syphilis which will be carried out by the local Board of Health in cooperation with the medical profession.

Dr. Tidaback, the President of the Summit Medical Society, introduced the speaker of the evening, Dr. G. D. Astrachan, Attending Dermatologist of the Skin and Cancer Unit, New York Post-Graduate Hospital, who gave an excellent address on "The Management of Early Syphilis."

Following the address a collation was served in the dining room of the Nurses' Home.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The regular annual meeting of the *Warren County Medical Society* was held Tuesday, October 19, in Hotel Belvidere, Belvidere, N. J., at 11 o'clock, with the President, Dr. James Weres, of Alpha, presiding.

Members and guests present were: Drs. William Varney, William Skinner, of Washington; Clyde Smith and Seymore Kimmel, of Oxford; F. A. Shimer, Laurence H. Bloom, Emery Krausz, Charles Lyon, Phillipsburg; Herman Baldauf, G. W. Cummins, N. C. Marlatt and D. P. D. Jackson, Belvidere; Frank Gordon, Blairstown; H. B. Bossard, Phillipsburg, R. D. No. 2, and the guest speaker, Dr. Thomas L. Smyth, President of the Lehigh County Medical Society, Allentown, Pa.

SCIENTIFIC

Dr. Smyth spoke on the x-ray, dwelling on its origin and history, and its use in the treatment of diseases, especially sinusitis. His paper was disucssed by the members present. Dr. Smyth was given a rising vote of thanks for his excellent paper.

NEW MEMBERS

Dr. Seymore Kimmel, of Oxford, and Dr. P. H. Weigel, of Washington, were elected to membership in the society.

TREASURER'S REPORT

Dr. G. W. Cummins gave the Treasurer's report.

Drs. L. H. Bloom and N. C. Marlatt were appointed as members of the Auditing Committee to audit the Treasurer's books.

ELECTION OF OFFICERS

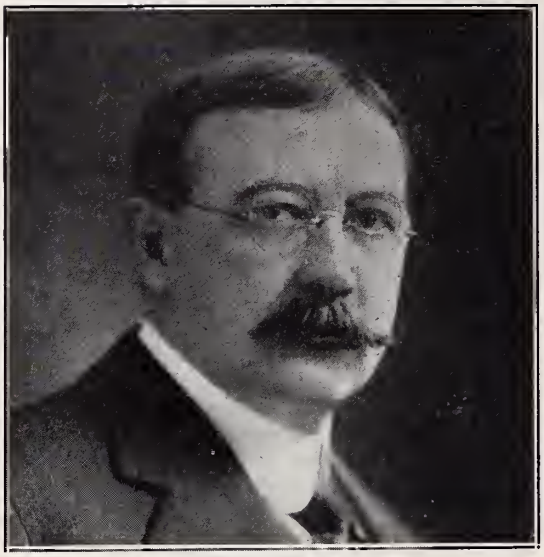
Drs. F. A. Shimer, H. Baldauf, and F. Gordon were appointed by President Weres on the Nominating Committee. They made the following nominations:

President, Dr. Clyde Smith, Oxford
Vice-President, Dr. W. R. Bostwick, Blairstown
Secretary, Dr. William Skinner, Washington
Treasurer, Dr. G. W. Cummins, Belvidere
Reporter, Dr. H. B. Bossard, Phillipsburg, R. D. No. 2
Censor, Dr. L. H. Bloom, Phillipsburg
Delegate to the State Society (three years), Dr. Frank Gordon, Blairstown
Alternate, Dr. James Weres, Alpha
Member of the Nominating Committee to the State Medical Society, Dr. H. B. Bossard, Phillipsburg, R. D. No. 2
Advisory Committee to the Woman's Auxiliary of the County Society: Drs. F. A. Shimer, H. Baldauf and Emery Krausz.

The report of the Nominating Committee was received and the candidates unanimously elected.

The meeting then adjourned to the dining room of the hotel where a turkey dinner was served to the members of the society and the Woman's Auxiliary.

OBITUARIES



DR. LEONIDAS L. MIAL

DR. LEONIDAS L. MIAL

Dr. Leonidas LeMay Mial died of cerebral hemorrhage on August 20, 1937, at his home in Morristown, after an illness of a week's duration. He was born on a farm near Raleigh, North Carolina, July 7, 1862. He graduated from the University of North Carolina in 1881, and from the University of Pennsylvania in 1887 with the degree of M.D. He spent the next year as an interne in the University Hospital, and then joined the staff of the New Jersey State Hospital at Greystone Park.

Dr. Mial entered private practice in New York City and specialized in diseases of the eye, ear, nose and throat, and served on the staff of the Manhattan Eye and Ear Hospital. In 1905 he came to Morristown to live and practice, and for many years was consultant in ophthalmology in All Souls' Hospital in Morristown, and at the New Jersey State Hospital at Greystone Park. He also served on the staff of the Morristown Memorial Hospital.

Throughout his life, Dr. Mial earned and retained the respect of his colleagues. They who knew him valued his friendship and advice.

DR. BLASE COLE

Dr. Blase Cole, of Newton, Sussex County, New Jersey, an active member of the Board of Trustees of The Medical Society of New Jersey, died on Thursday, September 30, 1937, as the result of an automobile accident which occurred while he was returning home from a game of golf. He was a native of Sussex County, the son of Dr. Martin Cole, and was born in Hainesville, November 21, 1879. He graduated from Princeton University in 1903, and obtained his M.D. degree from the University of Pennsylvania in 1907.

Dr. Cole served as interne in St. Timothy's Hospital, Philadelphia, and the New Jersey State Hospital in Greystone Park. He then joined the Medical Corps of the United States Army, and was stationed at Fort Leavenworth, Kansas, for several months. In 1911 he began the practice of medicine in Newton, N. J., specializing in surgery.

In April, 1917, Dr. Cole reëntered the Army as Captain and served overseas with Base Hospital No. 66 in Neuf Chateau, France, until the end of the war. He then resumed his practice in Newton.

Dr. Cole followed the example of the public-spirited physicians of a century or more ago, and served his community and State in a civic capacity. He was elected State Senator in 1924 and served three terms, always promoting the cause of scientific medicine in coöperation with The Medical Society of New Jersey. In June, 1930, he was appointed a member of the State Court of Errors and Appeals.

An editorial in the New Jersey Herald of October 7, 1937, said:

"Judge Cole's life was as varied as it was interesting; athlete, physician and surgeon, soldier, senator, banker, and judge. He entered each field with zest and enthusiasm; however, his main talent lay in medicine and surgery. In his profession he stood second to none. He loved life and all that it had to offer. His personality was magnetic, and his presence was always felt."

LIST OF PHYSICIANS DYING IN NEW JERSEY IN SEPTEMBER, 1937

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Gibbs Chisholm	43	Sept. 17	Newark	Newark	Addison's disease
Blase Cole	57	Sept. 30	Paterson	Newton	Automobile accident
Thomas S. Davis	84	Sept. 12	Plainfield	Same	Cerebral embolism
Clarence Garrabrant	81	Sept. 30	Atlantic City	Atlantic City	Chronic prostatitis
Thomas Kenyon	71	Aug. 2	Neptune	Weehawken	Dislocation of vertebrae, while in swimming
Joseph A. Ryan	33	Sept. 25	Newark	Chatham	Pulmonary tuberculosis

THE WOMAN'S AUXILIARY

THE EXECUTIVE BOARD MEETING

The Fall meeting of the Executive Board of the Woman's Auxiliary to the Medical Society of New Jersey was held Monday, October 11, 1937, at the home of the President, Mrs. Samuel L. Salasin, in Atlantic City.

The meeting was called to order by the President at 10:30 a. m. The following members were present:

Mrs. LeRoy A. Wilkes, Mercer County
Mrs. H. V. Hubbard, Union County
Mrs. O. R. Carlander, Camden County
Mrs. A. J. Casselman, Camden County
Mrs. F. A. Kinch, Union County
Mrs. Carl A. Surran, Atlantic County
Mrs. A. H. Lippincott, Camden County
Mrs. Lawrence Wilson, Atlantic County
Mrs. J. H. Hornberger, Burlington County
Mrs. Charles Rathgeber, Essex County
Mrs. Chester Ulmer, Gloucester County
Mrs. Don B. Weems, Gloucester County
Mrs. S. E. McDonnell, Burlington County
Mrs. A. W. Bickner, Bergen County
Mrs. Ily R. Beir, Atlantic County
Mrs. Walter Farr, Bergen County
Mrs. H. R. Van Ness, Essex County
Mrs. Thomas P. McConaghy, Camden County
Mrs. C. F. Adams, Mercer County

The Treasurer, Mrs. Thomas P. McConaghy, moved that all moneys be kept in one account, and recorded under three headings, namely Annual Meeting Fund, General Meeting Fund, and the A. M. A. Fund. This motion was seconded and carried.

The budget for the year's expenditures was read and accepted.

A motion by Mrs. Frederick A. Kinch, seconded by Mrs. O. R. Carlander and carried, approved a check for $25.00 be paid to Mrs. George A. Rogers for expenses incurred by her as Official Delegate to the Auxiliary of the American Medical Association Convention of June, 1937.

The Advisory Committee appointed by the State Medical Society is as follows:

Dr. Samuel L. Salasin, Chairman, Atlantic City
Dr. A. E. Jaffin, Jersey City
Dr. L. G. Beisler, Hillside
Dr. William K. Campbell, Long Branch

Letters from Drs. S. T. Snedecor, Charles B. Kaighn, and William G. Herrman were read, expressing appreciation for the work done at the convention by the Auxiliary.

It was moved by Mrs. A. Haines Lippincott, seconded by Mrs. O. R. Carlander that the usual contribution of $5.00 be sent to the Yardley Foundation, which is sponsored by the State Federation of Women's Clubs. This was carried.

A letter from Dr. J. H. Kler stated that return postcards were being sent to each physician's wife asking for information regarding clubs other than the Auxiliary in which she is interested. It is important that these be returned properly filled in, so that the cards can be filed in the Executive Offices.

The book list approved by the Medical Society will be published in the Calendar for the year. Members are requested to buy these books if possible, and place them in libraries, and to use their influence to have librarians or library boards purchase them.

It was suggested that the Committee on Legislation and Education in other clubs be asked to cooperate with the Auxiliary in the fight against venereal diseases, the Auxiliary to furnish the speakers.

Announcement was made of the broadcast which began October 13, by the A. M. A., and which will continue through the winter on Wednesdays from two to two-thirty p. m., the subject to be "The Youth of America". Members are requested to contact Boards of Education or School Superintendents, asking them to coöperate in having their assembly periods at this time to permit high school students to listen in.

Mrs. Carl Surran moved, Mrs. Kinch seconded the motion, that her expense account of $50.00 advanced by her for convention expenses be approved. This was passed.

Mrs. LeRoy Wilkes presented the suggestion that the Board Room of the Executive Offices at Trenton be used for the January meeting if it were not to be used by the Medical Society at that time. This suggestion was accepted.

Organization: Mrs. J. H. Hornberger, Chairman, reported that inasmuch as all unorganized counties had been well canvassed, she was advised to nothing further.

It was stated that all counties which had contributed to the General A. M. A. Fund would receive a report of expenditures.

Printing: Mrs. Frederick Kinch, Chairman, reported that the handbooks had been ordered, but that they had not yet been received.

There being no further business, the meeting was adjourned to convene in Trenton in January; dinner to be served at the Stacy-Trent, one dollar per person, plus tip.

Respectfully submitted,

Mrs. C. F. Adams,
Secretary Pro Tem.

Atlantic County

Reported by Mrs. Morton Major

The first regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held at the Ambassador Hotel on Friday evening, October 8, 1937.

Mrs. Lawrence Wilson, President, stated her three objectives for the year. They are:

1. To give wholehearted coöperation in anything that is required by the County Society and State Auxiliary.

2. To place before lay groups speakers from the Atlantic County Medical Society.

3. To conduct an essay contest among children of the seventh and eighth grades on "Prevention of Common Colds".

Mrs. Harry Subin, social chairman, announced a card party on November 17, in the Ambassador Hotel for the benefit of the welfare fund.

Dr. Robert A. Kilduffe was guest speaker, and discussed "Medical History of Hospitalization". It was enlightening as well as most interesting.

A book will be given to the public library in memory of the late Dr. Clarence Garrabrant, who was a member of the Atlantic County Medical Society.

Present were: Mrs. Joseph Poland, Mrs. Louis Rosenberg, Mrs. Barney Barab, Mrs. Harry Subin, Mrs. James MacFarland, Mrs. B. H. Timberlake, Mrs. Clarence Whims, Mrs. Arthur Von Deilen, Mrs. L. M. Walker, Mrs. Louis Feinstein, Mrs. Charles Hyman, Mrs. Bernard Crane, Mrs. Lawrence Wilson, Mrs. Percy Joy, Mrs. Allan Reick, Mrs. G. Ruffin Stamps, Mrs. V. E. Johnson, Mrs. Robert Kilduffe, Mrs. Morton Major.

Bergen County

Reported by Mrs. Francis A. Macaulay

The regular meeting of the Auxiliary was held on Tuesday evening, October 12, at Hackensack Hospital, Mrs. Walter Fair, President, presiding.

At the business meeting it was voted to present each Past President of the Auxiliary with a President's Pin at the next meeting.

For our program we joined the doctors' meeting, and heard Dr. Henry H. Kessler, of Newark, on rehabilitation surgery (p. 697).

Camden County

Reported by Mrs. L. L. Glover

The September meeting of the *Executive Board of the Woman's Auxiliary to the Camden County Medical Society* was held at the home of Mrs. O. R. Carlander in Merchantville. The calendar for the year was presented and discussed. The following meetings were planned:

October 5, an Oriental Tea, at the home of Mrs. Joseph E. Roberts in Haddonfield.

January 5, book reviews at the home of Mrs. O. R. Carlander.

March 8, a Reciprocity Meeting.

May 3, the third Annual Luncheon and election of officers.

Plans were discussed for a Rummage Sale for the purpose of raising funds for a number of Y. W. C. A. scholarships to be given to student nurses. This is being done to encourage the nurses to use the facilities of the Y. W. C. A. building.

A card party and fashion show has been planned for the seventh of March at the Walt Whitman Hotel in Camden, for the benefit of the Tuberculosis Hospital at Lakeland.

At the conclusion of the business meeting, tea was served. The President's Mother, Mrs. Maude S. Utley, and Mrs. O. W. Saunders poured.

Those present were: Mrs. H. Wesley Jack, Mrs. E. Reed Hirst, Mrs. Thomas P. McConaghy, Mrs. Laurence L. Glover, Mrs. Oram R. Kline, Mrs. Robert S. Gamon, Mrs. Reba G. Busbey, Mrs. Gordon F. West, Mrs. William J. Scruggs, Mrs. A. Lincoln Sherk, Mrs. O. W. Saunders, Mrs. Lester R. Wilson, Mrs. Edward C. Pechin, Mrs. George B. German, Mrs. Joel Fithian.

The Fall meeting of the *Woman's Auxiliary to the Camden County Medical Society* was an Oriental Tea held at the home of Mrs. Joseph E. Roberts in Haddonfield.

Mrs. A. Haines Lippincott, of Camden, spoke on "Plans for the Auxiliary's Future" and presented an original monologue based on a visit to a charlatan's lecture in Atlantic City.

Mr. A. L. Baker, of the "Sign of the Heathen Dog" in Philadelphia, spoke on "Chinese Art in the American Home". Mr. Baker is a graduate of the University of Washington, and has traveled extensively in China and Japan.

Mrs. E. J. Alden, of Collingswood, dressed in native Chinese costume, sang two Chinese songs.

Mrs. Edward C. Pechin, of Haddonfield, and Mrs. Robert S. Gamon, of Merchantville, both Past Presidents, poured. Mrs. O. W. Saunders, of Camden, hospitality chairman, assisted by the following committee, planned the affair:

Mrs. A. Lincoln Sherk, Mrs. William Braun, Mrs. Alfred M. Elwell, of Camden; Mrs. P. H. Thompson, of Merchantville, and Mrs. K. MacAlpine, of Gloucester.

Chinese Mandarin costumes were worn by the hostesses and those pouring.

The President of the society, Mrs. Oswald R. Carlander, of Merchantville, presided.

Essex County

Reported by Mrs. S. H. Jessurun

Dr. Edward J. Ill was speaker and guest of honor at the annual luncheon meeting of the *Woman's Auxiliary to the Essex County Medical Society* held at L. Bamberger & Co. restaurant on Monday, May 26, 1937.

A history of the Medical Society's work for the Widows and Orphans Fund was given by Dr. Ill, who has served as President of that fund for more than fifty years. The speaker told of the embarrassment of doctors' families when left without funds, and their unwillingness to accept charity. The organization for widows and orphans has been meeting this need for many years, he pointed out, asking for additional membership.

Relief coming from the fund in needy cases can

be received as a right and not a charity, Dr. Ill said. He pointed out that the fund is created from membership dues, and a small fixed assessment on all members upon the death of any member. Dr. Ill was introduced by Mrs. Theodor Teimer, Chairman of the Fund in the State Auxiliary.

A birthday cake bearing his name and lighted candles surprised the guest speaker, as Dr. Ill's birthday happened to fall on the previous day.

Mrs. Fred G. Shaul, of Bloomfield, retiring President, was presented with the honorary pin which every Past President receives.

Mrs. Charles Rathgeber was introduced as the President for the ensuing year.

The following officers and chairmen were appointed:

President-Elect, Mrs. Gustave A. Braun
Vice-President, Mrs. Albert L. Harden
Recording Secretary, Mrs. I. H. Young
Corresponding Secretary, Mrs. Albert L. Harden
Treasurer, Mrs. S. H. Baldwin.

Chairmen of all committees are as follows:

Program and Health Education, Mrs. J. Irving Fort
Public Relations, Mrs. Louis Schneider
Membership, Mrs. Don Epler
Press and Publicity, Mrs. S. H. Jessurun
Cheer and also Widows and Orphans, Mrs. William Minningham
Historian, Mrs. Manfred Kraemer
Hospitality, Mrs. Earl Snavely
Ways and Means, Mrs. J. W. Siegel
Legislation, Mrs. E. Newman
Printing, Mrs. William Crecca
Telephone, Mrs. John Flannigan
Arts and Hobbies, Mrs. Theodor Teimer

Members of the *Executive Board of the Woman's Auxiliary to the Essex County Medical Society* were entertained at a delightful luncheon held at the Academy of Medicine on Monday afternoon, June 2, 1937, by the new President, Mrs. Charles Rathgeber. She gave a brief outline of the plans for the ensuing year, and dwelt at length upon the form of entertainment for the benefit of the Medical Benevolent Fund, which will take place in November.

The *Executive Board of the Woman's Auxiliary to the Essex County Medical Society* were guests of the President, Mrs. Charles Rathgeber, at a luncheon given for them at the Echo Lake Country Club in Westfield, New Jersey, on Monday, September 27, 1937.

The Program Chairman, Mrs. J. Irving Fort, gave a brief outline of the interesting plans to be developed during the ensuing year. Most interesting is the subject of Mrs. Estelle Sternberger's address, "The Outlook for Democracy", to be delivered at the general Auxiliary meeting which will take place on Monday, October 25, 1937, at L. Bamberger & Co. private dining room.

Members will attend the luncheon before the meeting.

October Meeting

The *Woman's Auxiliary to the Essex County Medical Society* held its first business meeting of the year on October 25, 1937, with 120 members present. Mrs. Charles Rathgeber, President of the Auxiliary, presided.

Mrs. J. Irving Fort, program chairman, introduced the speaker of the afternoon, Mrs. Estelle Sternberger, Executive Director of World Peaceways and the mother of a physician. She spoke on "The Outlook of Democracy". She advocated a constitutional amendment requiring a popular referendum before a declaration of war, and urged the application of the Neutrality Act.

Twenty-nine new members were added to the roll of membership. Mrs. Don Epler, Chairman of Membership, had worked out a plan with her committee that resulted in the increase of membership.

The meeting closed with a luncheon. The arrangements for the meeting were in the hands of a committee consisting of Mrs. Earl Snavely, Chairman; Mrs. Charles Rich, Mrs. R. Hunter Scott, Mrs. Harry Comando, Mrs. Charles Barkhorn, Mrs. Jerry Hayes, Mrs. Albert Harden, Jr., Mrs. Robert Roh, Mrs. James Lowrey, Mrs. Edgar A. Ill, Mrs. J. Wall, Mrs. J. Wallace Hurff, Mrs. LeRoy Kirkman, Mrs. Charles Zehnder, Mrs. Gordon P. Goodfellow, Mrs. Joseph A. Clarken, and Mrs. Elbert A. Curtis.

Hudson County

Reported by Nellie D. Nevin

The opening meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held on Monday, October 4th, at the Y. W. C. A., with the newly elected President, Mrs. Charles B. Kelley, in the chair, and forty-seven members present.

ADDRESS BY DR. COPELAND

"Immigration" was the subject chosen by the guest speaker, Dr. Royal S. Copeland, United States Senator from New York. He told of the requirements for the naturalization of aliens, stressing the increased restrictions since 1921 with respect to physical fitness.

He also spoke of the increase of crime in America, and declared that, contrary to belief, the majority of criminals were not the foreign born, but of American stock.

The Senator closed by urging each one present to assume individual responsibility in discussing and helping to solve the great problems with which America is confronted at the present time.

GUEST ARTIST

Mme. Phyllis De Rosa was the guest artist. She sang a group of three songs accompanied on the piano by Miss Christine Nelten.

PLANS

Mrs. Henry Broeser, Chairman of Program, and Mrs. Joseph J. Ruvane, Chairman of Entertainment, outlined some of their coming activities, after which the usual social hour followed.

Mercer County

Reported by Mrs. Leonard L. Friedman

The Executive Committee of the *Woman's Auxiliary to the Mercer County Medical Society* met at the home of Mrs. C. Chester Chianese on September 30th.

The program of respective meetings and the activities for the year were discussed.

Officers and chairmen of the standing committees for the year 1937-38 were named as follows:

Mrs. C. Chester Chianese, President
Mrs. James J. McGuire, First Vice-President
Mrs. A. Dunbar Hutchinson, Second Vice-President
Mrs. Leonard L. Friedman, Secretary
Mrs. Edward K. Hawke, Treasurer
Mrs. George N. J. Sommer, Nominating
Mrs. D. Leo Haggerty, Public Relations
Mrs. Robert J. Cottone, Program Health
Mrs. LeRoy A. Wilkes, Program Speakers
Mrs. William J. Abey, Flash
Mrs. William C. Ivins, Arrangements
Mrs. J. J. McGuire, Legislation
Mrs. H. Donald Cowlbeck, Art, Hobby, Medical History
Mrs. Alvin S. Rogers, Widows and Orphans
Mrs. Arthur Belting, Printing
Mrs. George A. Corio, Scrapbook
Mrs. J. J. Harman, Magazine

Membership Committee:
St. Francis Hospital, Mrs. F. A. McGuigan
Mercer Hospital, Mrs. E. D. Burroughs
McKinley Hospital, Mrs. Alton S. Fell
New Jersey State Hospital, Mrs. Charles E. Clark

Following the business, a social hour was enjoyed and tea was served by the hostess.

Mrs. George N. J. Sommer graciously presided at the tea table.

Mrs. C. Chester Chianese and Mrs. Robert J. Cottone attended the Regional Conference and luncheon held at the home of Mrs. Dan S. Renner, at Skillman, N. J., on October 4th.

A group of Medical Auxiliary members were entertained by our President, Mrs. C. Chester Chianese, at her home on Wednesday evening, October 13th.

Christmas dolls were dressed under the direction of Mrs. Vartan Kachdorian, who so generously contributed material for this work.

Twelve dolls were dressed.

The first regular meeting of the *Woman's Auxiliary to the Mercer County Medical Society* was held on Monday, October 18th, at the nurses' residence of St. Francis Hospital. Surgical dressings were folded during the afternoon.

Mrs. C. Chester Chianese, President, conducted the business session.

A solemn, silent tribute was paid in the memory of our departed member, Mrs. E. F. Purcell.

Dues were collected by Mrs. Burroughs in the absence of our Treasurer.

Reports of various committee chairmen were read.

Mrs. Charles F. Adams reported on the October Board meeting held at the home of Mrs. Samuel L. Salasin, State Auxiliary President.

The Public Relations Tea, Mrs. Haggerty, chairman, will be held at the Contemporary in March.

The program of the year was read, and the President urged all members to attend all meetings.

The January open meeting was discussed, to be held at the Stacy Trent Hotel.

Plans are under way for a very elaborate "Holiday Card Party" to be held at the home of our Mrs. Adams.

While our fingers were busy with the surgical dressings, the members listened very attentively to a most interesting reading by Mrs. George N. J. Sommer concerning the purpose, usefulness and beginning of the Medical Auxiliary.

Mrs. Haggerty spoke on the topic of the day, "The Community Chest".

The President introduced our guest speaker, Mrs. Walter P. Mongon, regent of the Parochial P.-T. A., Trenton District.

The ladies next convened in the living room for tea served by the kind Sisters. Mrs. F. A. McGuigan was chairman in charge of arrangements.

Vocal solos were rendered by Anna Giovanetti, assisted by Lily Oros at the piano.

Much enthusiasm was shown by the members at this meeting. It was well attended and we are enjoying an active, interesting year.

The next meeting will be held at the nurses' residence of Mercer Hospital on November 15th. It will be an all-day meeting.

Union County

Reported by Mrs. Herschel S. Murphy

The first regular meeting this year of the *Women's Auxiliary of the Union County Medical Society* was held Wednesday evening, October 13th, at the home of Dr. and Mrs. H. V. Hubbard, of Plainfield. Mrs. D. R. McElhinney, our new President, presided.

A motion was passed to present all our Past Presidents with the County Past President's Pin, and to continue this custom in the future.

Committee reports were heard, and plans for a full social calendar were made. Dues were raised fifty cents a year per person to cover increasing needs.

A five-minute medical paper on safeguarding the health of children before bringing out any trace of genius in them was read by Miss Arabelle Hubbard. The purpose of these talks,—to bring the topic of health before the lay organizations,—was again stressed.

Following this the group adjourned to another room where Mrs. Hubbard showed several moving pictures of the conventions at Atlantic City, and one of Miss Hubbard's college graduation. They were in color and were particularly interesting because of their personal touch.

Refreshments were then served by the hostesses, headed by Mrs. George Knauer, of Elizabeth.



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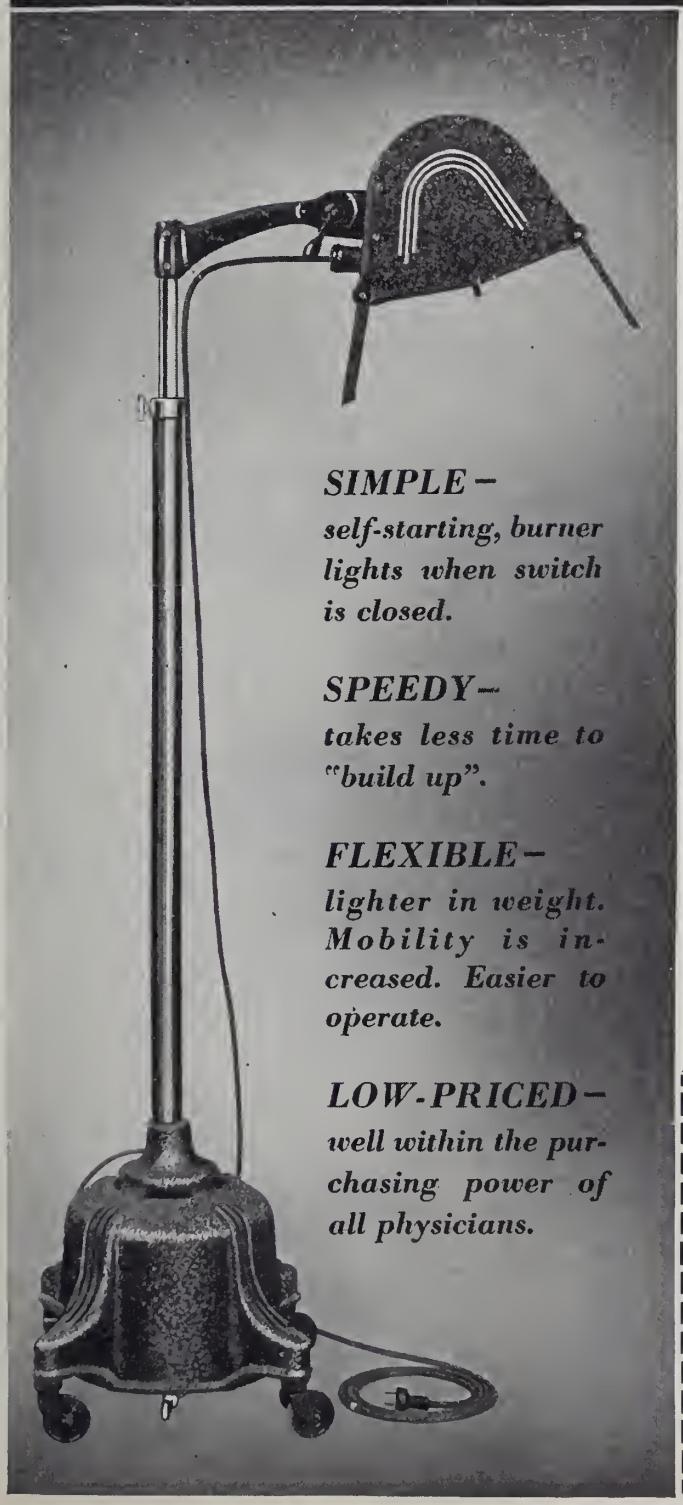
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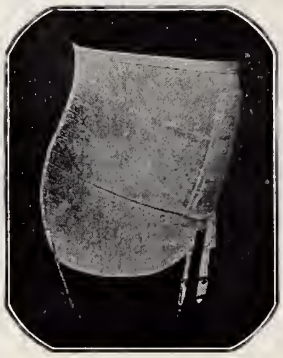
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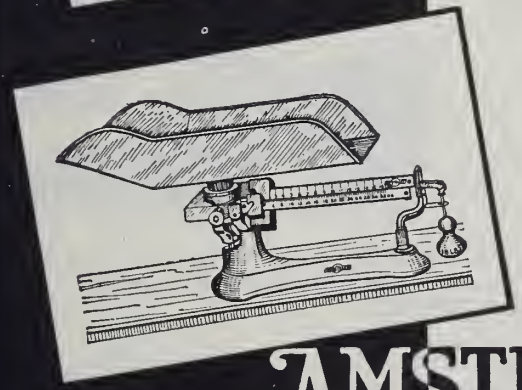
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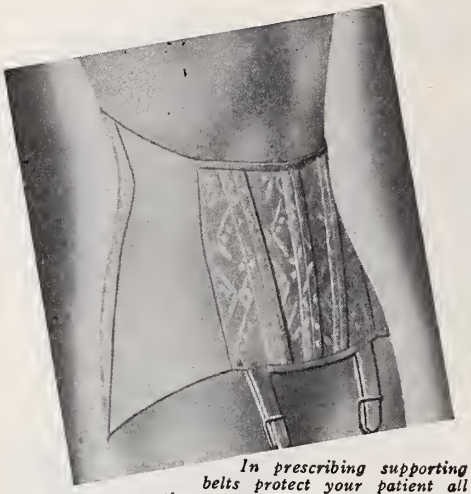
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VACCINES AGAINST COLDS

Abstract of a notice in the Jour. A. M. A., Oct. 2, 1937.

Last year a prominent chemical company advocated the use of a cold vaccine that can be administered by mouth, and placed its own product—entoral—on the market. The A. M. A. Journal of July 17, 1937, stated:

"After a consideration of the available evidence, it would seem that the hypothesis on which "Entoral" is based is inadequately supported by experimental evidence, and that the reports of its use contained in the literature are insufficiently documented. For these reasons the Council declared "Entoral" unacceptable for inclusion in New and Nonofficial Remedies."

Another firm is now marketing a tablet as a "Catarrhal Vaccine in enteric-coated tablet form", and claims that its administration by mouth will enable large industrial groups to receive immunizations at low cost. The advertising literature mentions experiments in which the tablets were given to the firm's own employees. The A. M. A. Journal properly asks: "Has any competent industrial surgeon actually established the usefulness of this preparation? Is it not likely that the firms hope to have the doctors introduce their oral vaccine preparations to the public as so many other nostrums or preparations of unestablished value have been introduced in the past?"

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Manganese (Mn)	None	None
Calcium (Ca)	13.7	0.80
Magnesium (Mg)	5.8	0.34
Sodium (Na)	5.6	0.33
Potassium (K)	Trace	Trace
Bicarbonic Acid, Radical (HCO_3)	43.1	2.52
Carbonic Acid Free (CO_2)	7.0	0.41
Sulphuric Acid, Radical (SO_4)	27.1	1.58
Nitric Acid Radical (NO_3)	1.8	0.11
Chlorine	4.2	0.25
Phosphorus	Trace	Trace
TOTALS	128.9	7.54
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Hydrogen Ion concentration, pH		
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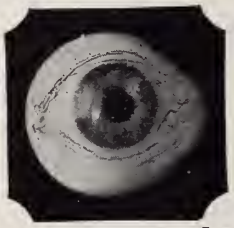
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THE JOURNAL

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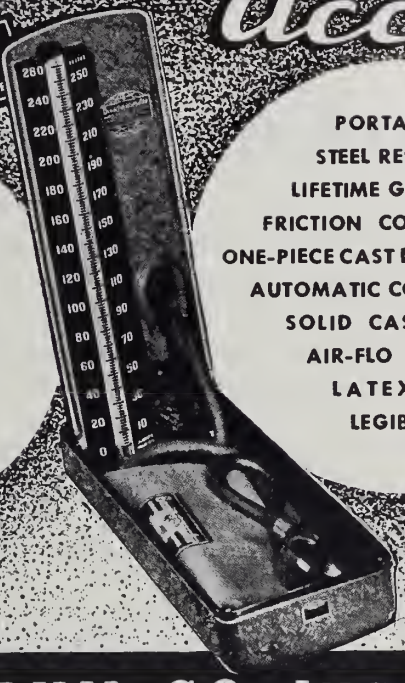
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If your car is disabled or involved in an accident and cannot proceed under its own power, a service car will tow you to the nearest garage, or to your home within a ten mile limit.

STARTING COLD OR FROZEN MOTORS
A sudden change in temperature during the winter months and your car will not start due to a weak battery or cold motor. A telephone call to headquarters and within a very short time you will be on your way.

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This is not a seasonal service. It may be clear in the morning and there may be a downpour of rain in the afternoon. Service men respond immediately, regardless of the weather.

TOURING AND MAP SERVICE
If you contemplate a trip, we will supply all necessary maps and complete itineraries.

24-HOUR SERVICE
Headquarters are never closed. Think of the feeling of security you will have knowing that whatever trouble you may be in, service is available 24 hours a day—365 days a year.

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Return the coupon below and complete details will be forwarded to you.

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Address..... *City*.....

Make of Car..... *Model*.....

Limits of Liability..... *Expiration Date*.....

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IF we could talk with you personally, Doctor, we would urge you . . . then and there . . . to taste Compound Syrup Calcreose. Its fine flavor we are sure would prove a most pleasant surprise.

Even then you might have a genuine prejudice against prescribing creosote generally in resistant cough cases through unpleasant experiences of gastric disturbance.

We urge a trial because we claim that Compound Syrup Calcreose is not only pleasant to the taste but will not cause gastric distress. Also it is decidedly effective.

If you, Doctor, will taste and try Compound Syrup Calcreose, we believe you will find it a dependable prescription and a constant source of satisfaction this coming cough season.

The formula of Compound Syrup Calcreose represents to each fluid ounce: Alcohol—16¾ mins.; Calcreose Solution—160 mins.; Chloroform—1/10 min.; Wild Cherry Bark—20 grs.; Aromatics and syrup—q. s.

Adult Dose: One to three teaspoonfuls every two or three hours.

Calcreose is the original brand of Calcium Creosotate U. S. P. XI.

Won't you instruct your secretary to write us today for a complimentary supply of Compound Syrup Calcreose to taste and try?

THE MALTBIE CHEMICAL COMPANY
NEWARK NEW JERSEY

GASTRIC TISSUE JUICE EXTRACT

ENZYMOL

Proves of special service in the treatment of pus cases

ENZYMOL resolves necrotic tissue, exerts a reparative action, dissipates foul odors; a physiological, enzymic surface action. It does not invade healthy tissue; does not damage the skin.

It is made ready for use, simply by the addition of water.

These are simply notes of clinical application during many years:

Abscess cavities
Antrum operation
Sinus cases
Corneal ulcer
Carbuncle
Rectal fistula
Diabetic gangrene
After removal of tonsils
After tooth extraction
Cleansing mastoid
Middle ear
Cervicitis

Originated and Made by

FAIRCHILD BROS. & FOSTER

NEW YORK

IN SINUSITIS AND HEAD COLDS

when you prescribe a liquid vasoconstrictor, consider three points:

1

PROLONGED EFFECTIVENESS

'Benzedrine Solution' produces a shrinkage which lasts 18 per cent longer than that produced by ephedrine.

2

MINIMUM SECONDARY REACTIONS

On continued use 'Benzedrine Solution' produces practically no secondary vasomotor relaxation.

3

REAL ECONOMY

'Benzedrine Solution' is one of the least expensive liquid vasoconstrictors.



BENZEDRINE SOLUTION

Benzyl methyl carbinamine, S.K.F., 1 per cent in liquid petrolatum with ⅓ of 1 per cent oil of lavender. 'Benzedrine' is the registered trade mark for Smith, Kline & French Laboratories' brand of the substance whose descriptive name is benzyl methyl carbinamine.

SMITH, KLINE & FRENCH LABORATORIES

Philadelphia, Pa. **Established 1841**

For adequate treatment of

PERNICIOUS ANEMIA

Lederle's "1 cc. Concentrated Solution Liver Extract" offers these advantages:

A high degree of therapeutic effectiveness—

A small volume for each injection—

A minimum of discomfort from each injection—

An individual dose container (additional safety)—

Economical treatment of the disease—a given amount of active material injected being equivalent clinically to from 30 to 50 times that amount taken orally—

It provides for the use of large amounts of active material which are frequently required for the treatment of the nervous system changes—

Relatively long intervals, 7 to 20 or more days, between injections—

Supplied only in boxes of 3—1 cc. vials

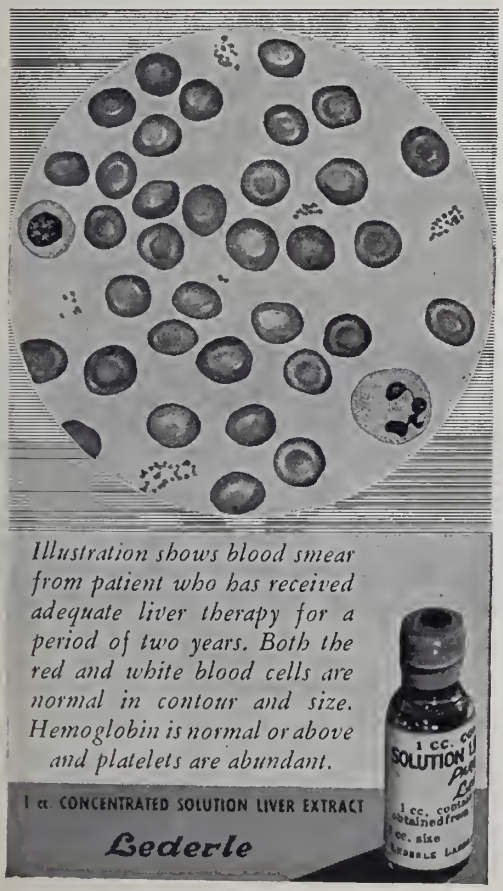


Illustration shows blood smear from patient who has received adequate liver therapy for a period of two years. Both the red and white blood cells are normal in contour and size. Hemoglobin is normal or above and platelets are abundant.

LEDERLE LABORATORIES, INC.
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When smokers changed to Philip Morris cigarettes, every case of irritation of the nose and throat due to smoking cleared completely or definitely improved.*

In Philip Morris, diethylene glycol is used exclusively as the hygroscopic agent, instead of the hygroscopic agent commonly employed.

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★*Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245* ☐
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154 ☐
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11 ☐
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60 ☐

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To increase the food intake of CALCIUM *and* PHOSPHORUS

The need for *increased* intake of Calcium and Phosphorus (among other things) is very great during pregnancy and lactation. Cocomalt has proved itself of especial value during these periods of stress.

For each ounce of Cocomalt has been fortified with .15 gram of Calcium and .16 gram of Phosphorus. Result: An eight-ounce glass of milk with one ounce of Cocomalt provides .39 gram of Calcium, .33 gram of Phosphorus. And, helping insure that the system can utilize the Calcium and Phosphorus, each ounce-serving of Cocomalt also contains 81 U.S.P. Units of Vitamin D, derived from natural oils and biologically tested for potency.

Cocomalt is Rich in Iron, Too

Each ounce-serving of Cocomalt provides 5 milligrams of effective Iron that has been biologically tested for assimilation. Thus, 3 glasses of Cocomalt and milk, leading authorities agree, supplies the normal patient's daily optimum Iron requirement.

It is for these reasons that physicians prescribe Cocomalt not only for expectant and nursing mothers but also for the correction of diet deficiencies in other patients. The creamy, delicious flavor of Cocomalt appeals to young and old alike. It is easy to digest. And Cocomalt is inexpensive . . . ½-lb., 1-lb. and the economical 5-lb. hospital size in purity-sealed cans are sold at grocery and drug stores.



Cocomalt is the registered trade-mark of R. B. Davis Co., Hoboken, N. J.

	1 Ounce of Cocomalt adds	1 Glass of Milk (8 Liquid Ozs.) contains	Result! 1 Glass of Cocomalt and milk contains
†IRON	0.005 GRAM	*TRACE	0.005 GRAM
†VITAMIN D	81 U. S. P. UNITS	*SMALL AMOUNT; VARIABLE	81 U. S. P. UNITS
†CALCIUM	0.15 GRAM	0.24 GRAM	0.39 GRAM
†PHOSPHORUS	0.16 "	0.17 "	0.33 "
PROTEIN	4.00 GRAMS	7.92 GRAMS	11.92 GRAMS
FAT	1.25 "	8.53 "	9.78 "
CARBOHYDRATES	21.50 "	10.97 "	32.47 "

★*Normally Iron and Vitamin D are present in Milk in only very small and variable amounts.*

† *Cocomalt, the protective food drink,* is fortified *with these amounts of Calcium, Phosphorus, Iron and Vitamin D.*

FREE: TO ALL DOCTORS

R. B. Davis Co., Hoboken, N. J. Dept. FF-12
I'll gladly try Cocomalt at your expense.
Doctor _____
Street and Number _____
City _____ State _____

CANNED FOODS IN THE CONTROL OF LATENT AVITAMINOSIS A

Cases of severe vitamin A deficiency are extremely rare in this country. Recent medical research, however, has shown that latent avitaminosis A occurs more frequently than hitherto might have been suspected (1).

Fortunately, latent avitaminosis is capable of early clinical detection. One of the first effects of prolonged suboptimal vitamin A intake is a lowered dark adaptation of the eye. Any deviation from normal in this respect can be readily determined by the photometer. A second direct result of continued mild avitaminosis A is the cornification of epithelial cells in certain tissues. The presence of such cornified cells in scrapings from the bulbar conjunctiva is indicative of avitaminosis A.

Using such methods, investigation has been made to determine the frequency of latent avitaminosis A in representative groups of American adults and children. The results of these researches are of interest to everyone concerned with human nutrition.

First, it has been shown that the incidence of latent avitaminosis A in America is surprisingly high. For example, in one instance (1d) more than one-third of the adult group under investigation displayed evidences of mild vitamin A deficiency; again, from one-fourth to three-fourths of the members of representative groups of children displayed similar manifestations (1b).

Second, it has been found that, in general, subjects exhibiting symptoms of mild avitaminosis A had been maintained on diets which may be considered suboptimal with respect to vitamin A. Last, but by no means least, it appears that these avitaminoses may be corrected and controlled by specific vitamin A therapy; by readjustment of the diet to provide a more liberal supply of vitamin A; or by a combination of these two procedures.

When readjustment of the diet to increase the vitamin A intake is being considered, attention might well be directed to commercially canned foods. Biochemical research has established that the canned varieties of foods notable for their vitamin A content are valuable dietary sources of the vitamin (2).

Available at all seasons on practically every American market, commercially canned foods will prove economical and reliable in the formulation of dietary regimes calculated to control latent avitaminosis A.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

1a. 1934. J. Amer. Med. Assn. 102, 892.
b. 1936. Ibid. 106, 996.
c. 1937. Ibid. 108, 7 and 15
d. 1937. Ibid. 109, 756.
2. 1931. J. Nutrition 4, 267
1932. Ind. Eng. Chem. 24, 650.
1933. J. Amer. Diet. Assn. 9, 295.
1935. Amer. J. Public Health 25, 1340.

This is the thirty-first in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

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INTRAVENOUS SOLUTIONS IN VACOLITERS



They're the finest that we know how to make

When the operation's done, they've wheeled your patient away . . . when little doubts and fears keep querulously asking, wondering . . . there's *one* that won't trouble you.

Granted you needed and used an intravenous solution, granted that you specified Baxter's in Vacoliters . . . *we* think you'll feel a sense of security knowing that BAXTER'S will do *its* part.

Baxter's . . . in Vacoliters . . . will do its part because all it has to do has been planned and made sure, so that it *will* do the helpful healing task you use it for.

It is *sterile*, as sterile as that word means . . . *your* patient will not be in danger. It is *stable* and the solution you think you've injected *is* the solution you *have* injected. You can have peace of mind there, too.

In medicine and in surgery there are a few fine things that have no counterpart. Solely by right of their quality they stand apart from their kind to give you peace of mind, a surety in action and a certainty that is incomparable.

These are descriptive of Baxter's Intravenous Solutions in Vacoliters. They give you peace of mind . . . are the finest that we know how to make.

The fine product of

BAXTER LABORATORIES

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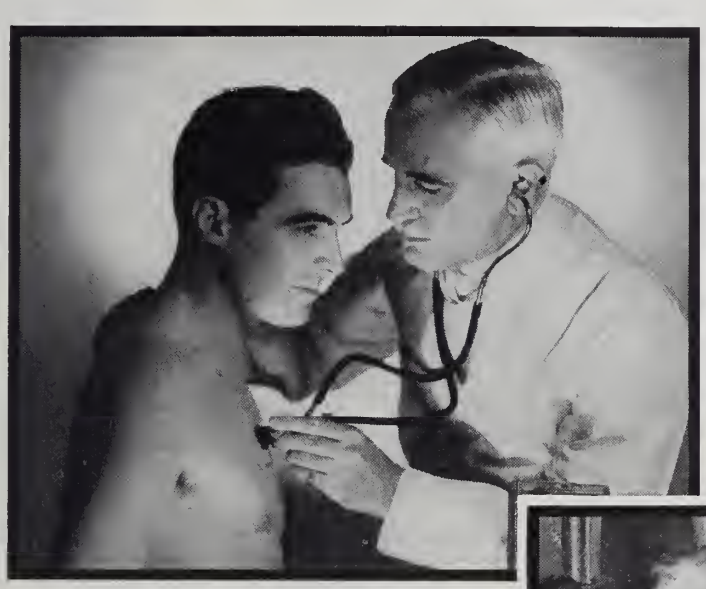


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THE AMERICAN HOSPITAL SUPPLY CORPORATION

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GETTING AS CLOSE TO GODLINESS AS IS HUMANLY POSSIBLE

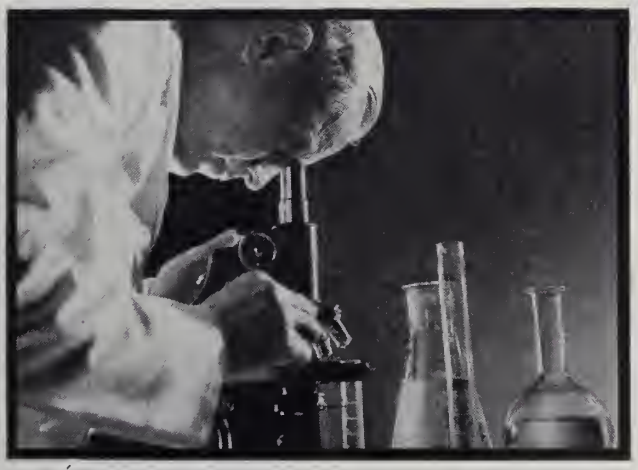


Cleanliness Is Bill Todd's Eleventh Commandment—he works in a Walker-Gordon milking room and knows we'd rather have the milking stop altogether than have him neglect a single detail of the elaborate procedure that helps make Walker-Gordon Certified the cleanest of milks. Daily his uniform is sterilized and laundered, his health checked.



We See the Baby when We Milk this Cow—so we work for super-cleanliness at the milk's first contact with the outside world. A Walker-Gordon cow is kept clipped and groomed as is no other cow; before each milking she is washed thoroughly and dried with her own clean, sterilized towel; she is milked in a room used for no other purpose. An absolute minimum of contact with humans, or even air, has been established in bringing Walker-Gordon Certified Milk to children.

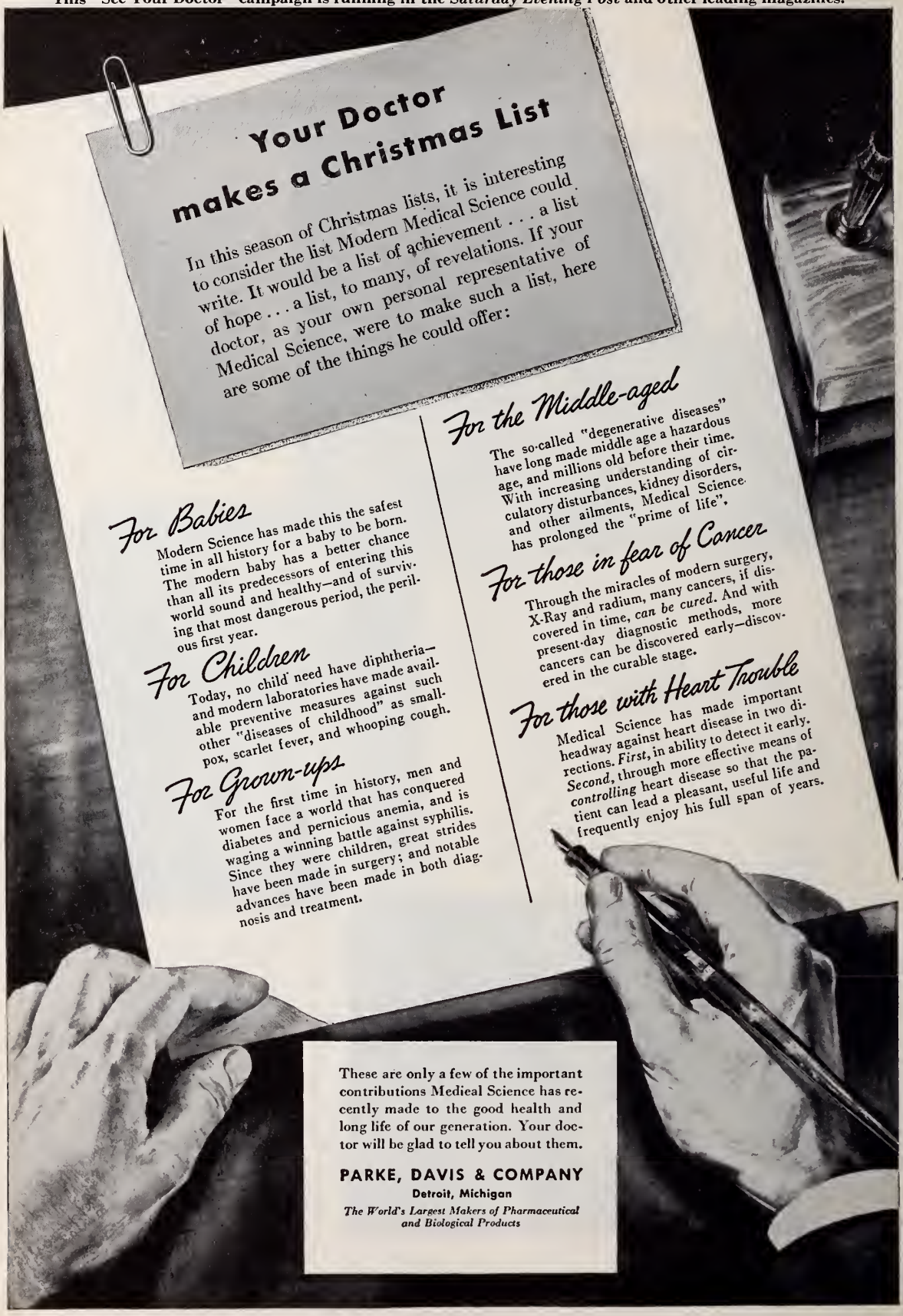
We Find our Reward with a Microscope—constant daily checks affirm that always, right from the start, right from the super-clean cows and their super-clean milking rooms, Walker-Gordon Certified is a fundamentally clean milk—*not* an unclean milk made safe. Regularly taken samples consistently show a bacterial count that averages two-thirds less than is required for Certified Milk.





Pennies for Health—the price of Walker-Gordon Certified—the milk made especially for children from nine months before birth to nine years after—is much lower than it used to be, only a few pennies more than that of grade A milk...perhaps the cost of a newspaper.

One of a series of advertisements prepared and published by PARKE, DAVIS & CO. in behalf of the medical profession.
This "See Your Doctor" campaign is running in the *Saturday Evening Post* and other leading magazines.



Your Doctor makes a Christmas List

In this season of Christmas lists, it is interesting to consider the list Modern Medical Science could write. It would be a list of achievement . . . a list of hope . . . a list, to many, of revelations. If your doctor, as your own personal representative of Medical Science, were to make such a list, here are some of the things he could offer:

For Babies

Modern Science has made this the safest time in all history for a baby to be born. The modern baby has a better chance than all its predecessors of entering this world sound and healthy—and of surviving that most dangerous period, the perilous first year.

For Children

Today, no child need have diphtheria—and modern laboratories have made available preventive measures against such other "diseases of childhood" as smallpox, scarlet fever, and whooping cough.

For Grown-ups

For the first time in history, men and women face a world that has conquered diabetes and pernicious anemia, and is waging a winning battle against syphilis. Since they were children, great strides have been made in surgery; and notable advances have been made in both diagnosis and treatment.

For the Middle-aged

The so-called "degenerative diseases" have long made middle age a hazardous age, and millions old before their time. With increasing understanding of circulatory disturbances, kidney disorders, and other ailments, Medical Science has prolonged the "prime of life".

For those in fear of Cancer

Through the miracles of modern surgery, X-Ray and radium, many cancers, if discovered in time, *can be cured*. And with present-day diagnostic methods, more cancers can be discovered early—discovered in the curable stage.

For those with Heart Trouble

Medical Science has made important headway against heart disease in two directions. *First*, in ability to detect it early. *Second*, through more effective means of *controlling* heart disease so that the patient can lead a pleasant, useful life and frequently enjoy his full span of years.

These are only a few of the important contributions Medical Science has recently made to the good health and long life of our generation. Your doctor will be glad to tell you about them.

PARKE, DAVIS & COMPANY
Detroit, Michigan
The World's Largest Makers of Pharmaceutical and Biological Products

In both acidosis and alkalosis, Karo is a carbohydrate of choice in the emergency of treatment . . .

CAUSES OF ACIDOSIS		CAUSES OF ALKALOSIS	
EXCESSIVE ACID FORMATION		EXCESSIVE LOSS OF ACIDS	
Acid	*Disturbance*		Hyperventilation
	Starvation		Tetany
Aceto-acetic	Cyclic vomiting		Cerebral lesions (respiratory center)
B-hydroxybutyric	Diabetes	CO_2	Hysteria
	Ketogenic diet		Excessive crying
	Asphyxia		
Lactic	Intestinal intoxication		Vomiting
	Respiratory failure	HCl	Pyloric stenosis
	Shock		Intestinal obstruction
	Burns		
DEFECTIVE ELIMINATION		EXCESSIVE INTAKE OF ALKALI	
Metabolite	*Disease*	$NaHCO_3$	in Pyelitis
Phosphate	Nephritis		in Nephritis
	Emphysema		
Carbonic acid	Respiratory obstruction		
	Myocardial failure		
	Narcosis		

From Kugelmass' "Clinical Nutrition in Infancy and Childhood"—(Lippincott)

TREATMENT of acidosis is designed primarily to correct the underlying cause. **In most types, fluids and fruit juices with Karo are forced every hour.** In cases associated with ketosis (except where it is a disturbance in carbohydrate metabolism, as in diabetes mellitus) 20% dextrose is given intravenously at repeated intervals. In case of diabetes, insulin is given, by some authorities, simultaneously one unit for each gram of dextrose, until the condition is controlled.

TREATMENT of alkalosis depends upon the cause. The most common variety in children is that resulting from prolonged vomiting with loss of acid, salt and body water. **No food is given by mouth except fluids with Karo,** and saline injected intravenously. If alkalosis is the result of alkali administration in the presence of nephritis with poor kidney excretion of salts, **large amounts of fluids with Karo will favor excess base elimination.** Alkalosis from excess alkali administration is alleviated by **forcing fluids with Karo.**

Karo consists of dextrins, maltose, and dextrose (with a small percentage of sucrose added for flavor), not readily fermentable, rapidly absorbed and effectively utilized.

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CORN PRODUCTS SALES COMPANY

Dept. SJ, 17 Battery Place, New York, N. Y.



★ **Infant feeding practice is primarily the concern of the physician, therefore, Karo for infant feeding is advertised to the Medical Profession exclusively.**



COLDS usually run their course...

...but the patient appreciates symptomatic relief of the nasal congestion.

An effective way to promote free breathing and relieve the "stuffed-up" feeling in colds, rhinitis and sinusitis, is the instillation of

NEO-SYNEPHRIN HYDROCHLORIDE

(levo-meta-methylaminoethanolphenol hydrochloride)

EMULSION

When Neo-Synephrin Emulsion is applied topically to the nasal mucosa, the low surface tension insures thorough and even spreading over the mucous membrane. The vaso-constrictive action is accomplished without sting and, in the dosage recommended, Neo-Synephrin does not usually produce "nervousness" or insomnia.

DOSAGE FORMS OF NEO-SYNEPHRIN HYDROCHLORIDE:

EMULSION— ¼% (1-oz. bottle with dropper)

SOLUTION— ¼% for dropper or spray, 1% for resistant cases } (1-oz. bottle)

JELLY— ½% (in collapsible tubes with applicator)

FREDERICK STEARNS & COMPANY

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From the small 2-story house shown above, H. J. Heinz Co. has developed into one of the greatest food producers on earth.

12 STRAINED FOODS *from the famous family of "57"*



STRAINED FOODS labeled "Heinz" have a background of dependability that is unsurpassed in the entire food industry. They are prepared with the same care and skill—and in the same *quality* tradition—that have made the "57 Varieties" famous for purity, uniformity and flavor since 1869.

Only The Best For Heinz

Extra-select fruits, vegetables, meats and cereals are used exclusively. Trained experts sort and wash these in spotlessly clean kitchens. All cooking is done in *air-tight* dry steam retorts. Vitamins, minerals and nutrients are retained to an unusually high degree. Even Heinz containers are *specially enamel-lined* as an extra safeguard.

Be Safe—Specify "Heinz"

Consider the facts carefully. You'll agree, Heinz Strained Foods are best for your patients . . . eminently deserving of your outspoken preference and recommendation. All 12 kinds bear the official Seal of Acceptance of the American Medical Association's Council on Foods of course.

57

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AMERICAN MEDICAL ASSN.
Council on Foods

Heinz Strained Foods bear *both* the Seal of Acceptance of the American Medical Association's Council on Foods and the famous "57" Seal of Quality. That is why you are *doubly* safe in recommending them!

HEINZ STRAINED FOODS



On the night before Operation

. . . worry and sleeplessness can be prevented. One pulvule of 'Sodium Amytal' (Sodium Iso-amyl Ethyl Barbiturate, Lilly), 3 grains, usually insures a good night's rest. On the following morning, if the dose is repeated an hour or more before transference to the operating room, there is assurance of basal hypnosis, and induction of anesthesia will be easier for both patient and anesthetist. The total quantity of anesthetic required will be reduced—an important factor in smooth postoperative convalescence.

'Sodium Amytal' is also suggested for general medical use.

Supplied in 1-grain and 3-grain pulvules (filled capsules) in bottles of 40 and 500.

ELI LILLY AND COMPANY

Principal Offices and Laboratories, Indianapolis, Indiana, U. S. A.

Volume XXXIV.
Number 12

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly

Under the
Direction of the
Committee on Publication

Editor of
The Journal
Frank Overton, M.D., Dr. P.H.

Editorial and Executive Offices of the Society
143 East State Street, Trenton, N. J., Tel. 9330
Executive Officer—LeRoy A. Wilkes, M.D.
Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. XXXIV, No. 12 December, 1937 Subscription, $3.00 per Year
Single Copies, 30 Cents

EDITORIALS

The Conference of State Secretaries and Editors

The importance of the annual Conference of the Secretaries and Editors of the State Components of the American Medical Association is in some respects equal to that of the annual meeting of the national organization, for the conference reveals the methods and spirit with which the state associations carry out the details of the broad policies of the unified profession of the United States. The American Medical Association is a union of preëxisting State Societies, just as the nation is a union of States, each of which maintains its individuality.

There is a sameness and unity in the objectives of every State Medical Society; but the methods of attaining those objectives vary as widely as the forms of organization of the State governments. At the present conference each representative had the opportunity to tell how his own State Society deals with the particular problem that was under discussion. The contrasting methods in the application of the Federal Security Law followed in New Jersey and Illinois were explained by their representatives, each of which was adapted to the previous experience and form of organization of the particular State.

The program of the conference had been arranged by Dr. Olin West, Secretary of the A. M. A., after consultation with every Secretary and Editor of the State Societies. The delegates chose their own Chairman, Dr. Walter F. Donaldson, of Pittsburgh, Pa.; and they did most of the talking, but with frequent appeals to the A. M. A. officials for information.

The fraternal spirit was dominant; and State officers who knew one another by correspondence and their Journals found themselves congenial companions as they talked both formally and informally. Many State Societies recognized the practical value of the acquaintances by sending their lay secretaries at the expense of the local societies.

About twenty subjects were discussed by the speakers covering almost the entire range of State Society activities. The addresses were unusually concise and practical. The entire proceedings, including the editorial evening, were taken by a stenotypist; and it is hoped that they will be available, in their full form, to every State Society.

The 1937 Index

This issue contains the index to Volume 34 of The Journal which, according to the custom of the past three years, is made up according to departments,—that of each section being made complete in itself.

The prevalent conception of the usefulness of The Journal is that it is principally a record of the scientific work done by its members. But The Medical Society of New Jersey is unique for the consistent development of its policies from its earliest days. The leaders of the Society have never been content with merely passing resolutions regarding the desirability of undertaking a new enterprise and then forgetting all about it. When a new project has been authorized, it has always been the custom to appoint a committee to put the new policy into execution; and to require the committee to make a report of its accomplishments. The reports of these committees have formed the bulk of the "Transactions" of the Society from its earliest days. These reports reveal the genesis of every one of the committees and boards of the present organization of the State Society, from their simple beginnings, through the assignments of their activities to subcommittees, and leading finally to the development of the present Board of Trustees and the central Welfare Committee of which practically all the present working committees are subdivisions.

The ancestor of the present Journal is the volume of *Transactions* covering the period of years from the foundation of the Society on July 23, 1766, and extending through the year 1858. The original handwritten volumes are still in existence in excellent condition in the library of the Newark Historical Society.

Beginning with the year 1859, the Transactions were printed in *annual volumes,* copies of which are on file in the Executive Offices of the State Society, and in the library of the Academy of Medicine of Northern New Jersey in Newark. A working agreement with the New York Academy of Medicine enables a research worker to have access to the records of other medical societies and organizations throughout the United States.

In September, 1904, the annual volume of Transactions was succeeded by the present *Journal,* which therefore became a current record of the Transactions of the State Society and its component county societies, month by month.

Medical practice of the present day consists of the collective activities of official medical societies as well as those of individual physicians; and of the response of civic organizations as well as individual citizens. With this meaning of "Medical practice" in mind, medical societies are the advisers of governmental and civic organizations in the same way that individual doctors are the medical advisers of individual citizens. A record of the actvities of the official medical societies is therefore of essential importance to every physician who practices medicine, whether or not he belongs to the county society of his locality.

The present index of The Journal divides the records of the medical societies themselves into two parts. First is the record of the activities of the *State Society* and its committees. Then the response of the *county societies* to each recommendation of the State Society is duly indexed under the name of each society which takes action on the subject. The index of the county societies fills as much space as that of the State Society. Another section of the index is devoted to the response of the Woman's Auxiliary to the projects of the State Society.

The records of all branches of the State Society and of every county society, so far as they are available, are on file in the Executive Offices; but the abstracts of those records in the State Journal is the source of information which is usually consulted. It is seldom that any essential record cannot be found in The Journal by means of its annual index. The index is therefore essential in tracing current medical events even before they attain the dignity of medical history.

Seasonal Activities

The physician engaged in the private practice of medicine is always on duty, performing the same round of services throughout the year; but the work of organized medicine is largely seasonable. The year of activity of The Medical Society of New Jersey, like that of agriculture, is divided into four seasons,—those of seed-time, of growth and development, of harvest, and of rest and planning for the coming year. These four seasons are clearly reflected in the "Journal", which, as its name implies, is a record of the orderly development of the activities of the Society throughout each year of administration.

1. SEASON OF PLANNING

The first administrative season of The Medical Society of New Jersey and of its component county societies begins at the close of the Annual Meeting in late Spring. This is a season of comparative *rest* for most of the members, except for the newly-elected officers who will be kept busy during the summer months of June, July, and August, planning the work of the coming year and assigning the fields of activity to the appointed officers and committeemen, who number over 200 in the State Society, and about 1000 in the county societies. The list of the State officers and committeemen will be found on the first three pages of each issue of The Journal; and its preparation has required a vast amount of time and thought by the incoming officers.

2. SEASON OF SEED-TIME

The second season, that of *seed-time,* extends through the Fall months of September, October and November, when the newly-appointed committees hold their meetings for consultation and planning. The current activities of the several committees of the administrative year center in the Welfare Committee, whose meetings are regularly recorded in The Journal.

The outstanding accomplishment of The Medical Society of New Jersey in the present period of seed-time is that of perfecting the organization of a system of *Field Physicians,* —one member of each county society—who will explain the services in public health and preventive medicine which are available to family doctors in his county, particularly in maternal welfare, and child health. This is New Jersey's solution of the problem of securing the enlightened coöperation of family doctors in those fields of practice which the Government is threatening to assume.

3. SEASON OF GROWTH AND CULTIVATION

The third period is that of *active growth and cultivation,* which extends through the winter months of December, January, and February. Those are the months of the greatest activities of all the committees of the State Society, and the county societies, whose record will be found in the current issues of The Journal.

4. SEASON OF HARVEST

The fourth period is that of *harvest,* which extends through the Spring months of March, April and May, and culminates in the Annual Meeting. During this period the officers and committees throughout the State will prepare their annual reports, and will compare their accomplishments with the ideal which they set out to attain. Judging by the extent of the organized activities of the Medical Profession during the current year, the reports will fill many more pages of The Journal than the 161 which were required to record the activities reported to the Annual Meeting of 1937.

The Medical Society of New Jersey has a consistent plan of progressive action whose object is to promote the delivery of all forms of modern medical service by physicians engaged in the private practice of medicine.

The United Army of Health

Physicians sometimes think that the delivery of medical service is simply a private matter between the doctor and the patient; but as a matter of fact, the doctor has always relied on other groups to deliver those accessory services which enable the patient to make use of his ministrations. For a century and a quarter after the founding of The Medical Society of New Jersey in 1766, most nursing services were delivered by volunteering neighbors who took turns "Sitting up" with the sick patient; while the bill for welfare relief was one of the largest items in every town budget. Even today the system of "Poor doctors" still persists, with physicians competing for the appointments.

The discovery and development of the germ theory of diseases in the decade of the '80's led family doctors to advocate the principle that boards of health should quarantine whole families in which a contagious disease existed, for physicians rightfully considered that the enforcement of isolation was a *legal* procedure which belonged under government control. Even today, most health officers in New Jersey are laymen. But the system of lay health officers imposed on physicians the duty of diagnosing contagious diseases in their incipiency, and in their mild forms; and in addition, the obligation to administer the proper antitoxins, and to give immunizations to the contacts. The frequent unwillingness of physicians to perform these unpopular tasks compelled Departments of Health to enter the fields of diagnosis, therapeutics, and immunizations in apparent competition with family doctors;—and as a matter of fact there were frequent grounds of complaint by both parties. But, no new system of civic service was ever born without the pains of travail.

The coöperation between The Medical Society of New Jersey and the State Department of Health has always been more harmonious than that in any other State of the Union. The Medical Society of New Jersey and the State Department of Health each is ready to render the kind of service for which it exists,—each group in full coöperation with the other. Yet in the face of this opinion of conscientious and experienced medical leaders, some physicians think that any form of government participation in rendering medical service is a usurpation of power over the practice of medicine.

ATTITUDE OF THE MEDICAL PROFESSION

Few people,—including many physicians,—do not realize the extent of the basis for the development of the close agreement which exists between the Medical Profession and the Official Department of Health. The Journal of The Medical Society of New Jersey devotes over three pages of each issue to listing the names of the two hundred and more officers and committeemen of the State Society who give hours and days of their time to the development of a workable system for providing the best available form of medical system to all classes of people. A thousand more physicians serve on similar committees of their county societies. One-quarter of the practicing doctors of New Jersey are therefore giving this altruistic service in whose benefits *all* physicians share. These figures indicate the prevailing attitude of the medical profession of New Jersey toward public health and preventive medicine. It is the result of the spontaneous evolution and extension of the old system that the neighbors of the sick person should assist the family doctor in giving those personal services which are now supplied by trained attendants and officials.

THE DEPARTMENT OF HEALTH

The second division of the great army of health conservers is the Department of Health, whose forces consist of the central office staff of two hundred, and a thousand and more field workers, composed of health officers, technicians, inspectors, and other trained workers. In this division of the army of health must be counted the practicing physicians, each of whom is charged with certain official duties in regard to contagious diseases.

VOLUNTARY HEALTH AGENCIES

The third division of the great army of health workers in New Jersey is composed of the voluntary health associations whose members number uncounted thousands. Anyone who attends the State meetings of the members of the New Jersey Tuberculosis League, and the Health and Sanitary Association, cannot fail to be impressed with the earnestness and enthusiasm of the members of these auxiliary forces.

UNITY OF ACTION

The members of the regular army of the medical profession are officers on detached duty. Each is an acknowledged leader and commander in his own local sphere of duty; and his efficiency depends upon two factors:

1. His comprehension of his opportunities and responsibilities, which are set forth in the "Handbook of Procedures in Preventive Medicine", issued by The Medical Society of New Jersey, and are explained in detail in the system of graduate lectures sponsored by the State Society.

2. His friendly contacts with a representative physician—the Field Physicians, one in each county—chosen by himself and his brother practitioners. This system is made possible by the allocation of $68,000 annually by the Federal Government, to be administered jointly by the State Department of Health and The Medical Society of New Jersey (p. 747).

THE FIELD PHYSICIAN

The scope of the service of the Field Physicians begins with Maternal Welfare and Child Health, since these are forms of practice in which a family physician is the most often confronted with emergencies in which he needs assistance. The essential assistance which the Field Physician will render to the family doctor is that of informing him how he may obtain the help of a consultant or a nurse of his own choice when he is confronted with a difficult case of prenatal conditions, obstetrics, or children's sickness. The best teacher of medicine is the consultant who has for his pupil a family doctor who has called him to a difficult case.

The procedure which the local doctor is to follow is reduced to its simplest form, so that delay and "Red tape" may be eliminated. Experience with the tentative operation of the system for a year has demonstrated its grateful acceptance by practitioners of medicine.

The system has no suggestion of "Government control" of medical practice; on the contrary it is an efficient means of *preventing* governmental domination. Its actual operation and management is in the hands of the officers of his own County and State Medical Society. It is an effective means by which the physicians of New Jersey may manage their own affairs, and practice pediatrics and obstetrics, according to the best standards of medical skill and knowledge.

Medical Ethics, or Economics?

Ethical problems are often referred to The Medical Society of New Jersey for solution without a clear understanding of their nature, and of the conditions under which they arise. The science of ethics is a development of that of economics; and a dispute is unduly dignified by being called "Ethical", when it properly belongs in the lower realm of economics.

The code of ethics of The Medical Society of New Jersey is that of the American Medical Association, which defines the professional obligations of physicians under three divisions:

1. To their patients.
2. To other physicians.
3. To the public generally.

These relationships are mutual and reciprocal,—patients have obligations to their doctors, the public to the medical profession, and physicians as a group to the individual doctor.

Both economics and ethics of professional relations were simple so long as medical practice consisted of service by an individual doctor to an individual patient. But the introduction of a third party between the doctor and

the patient gave rise to misunderstandings and disputes regarding the ethics of the relations.

QUARANTINE

First there came Health Departments which seemed to require the doctor to violate the fundamental principle of ethics—that the doctor should not disclose information without the consent of the patient. Reporting a case of contagious disease in a family resulted in the quarantine of the whole family, with no provision for their economic support. Under the stress, economic considerations often prevailed, and led the doctor to conspire with the family to subordinate the *ethical* consideration of protection of the public to the *economic* necessity to conceal the nature of the disease until the diagnosis was plainly evident, and scarlet fever or diphtheria, or typhoid fever had spread through the community. These conditions prevailed until the ethics of the doctors' relations were recognized and the people heeded their economic obligation to support the entire quarantined family and to pay the doctor for his services to those whose means of livelihood were taken away.

The problem of quarantine remains today nine-tenths economic and one-tenth ethical.

CONTRACT PRACTICE

The next conflict between ethics and economics arose over *contract practice,* beginning with lodge practice. This form of practice resulted in such flagrant abuses that it was soon discredited on both economic and ethical grounds. The precedent of the evils of lodge practice is sufficient to condemn a similar system of government control of medical practice among the indigent and those of small economic means. County medical societies are now earnestly engaged in developing agreements by which private practitioners shall render medical services to the needy, while governmental bodies attend to the economic duty of paying the doctor's bills, as under the E. R. A. system in New Jersey.

The conflict between ethics and economics also exists under the operation of workmen's compensation laws. Doctors now concede the necessity that companies engaged in manufacturing involving special health hazards, as in dye works and powder mills, shall employ expert physicians; but there shall remain ethical problems growing out of these economic relations.

SCHOOL PHYSICIANS

The employment of school physicians has given rise to ethical disputes which really belong in the realm of economics. One form of dispute arises from the custom of a few school boards to require the school physician to enter into a *contract* to perform duties which the board may require. The problem may readily be solved by the appointment of a school doctor, without requiring him to sign a contract. The duties of the school physician are well known and standardized, and there is no occasion that he should sign a contract in any form. The Hunterdon County Medical Society has solved the problem in a satisfactory way by arranging with the school boards and civic organizations to provide for paying doctors assigned by the medical societies for giving immunizations, while the expenses of nursing and clerical services and transportation of the children to centers shall be borne by local school boards and welfare organizations. The problem of ethics in regard to school physicians is predominantly one of *economics* in which physicians are willing to perform their civic duties, provided the other organizations discharge their economic obligations.

The question of ethics arises when school boards and welfare officials attempt to impose an undue share of the economic burden upon physicians.

ORIGINAL ARTICLES

ANEMIA

By Asher Yaguda, M.D., Newark, N. J.

Read before the Atlantic County Medical Society, October 9, 1936, at Atlantic City, N. J.

It is important to stress at the outset that blood dyscrasias or diseases are not disorders inherent in the blood itself; but rather physical evidence of underlying anatomic or functional abnormalities of blood formation or blood destruction. The blood-forming organs, consisting of the bone marrow, the lymphoid structures of the body, and the reticulo-endothelial system, constitute a scattered and widespread system of hematopoiesis (blood-building), and contribute to the maintenance of what we all recognize as the so-called normal blood picture,—the bone marrow by the production of red blood corpuscles, granular leucocytes, and blood platelets; the lymphoid structures by the supply of lymphocytes; and the reticulo-endothelial system by the production of monocytes, and the removal of worn-out or functionless red blood cells from the circulation.

CLASSIFICATION

Anemias have been classified heretofore from many standpoints. The most common classification and one which is still used in many places is the division of anemias into *primary* and *secondary* types. This is manifestly unsatisfactory both from a clinical and a laboratory viewpoint.

Perhaps the most satisfactory *clinical* classification of anemias is that which groups them from an *etiologic* standpoint. This consists of separating anemias into two large groups:

I. Those anemias in which there is no defect in red blood cell formation, but where there is a loss of blood from the body, or a destruction of the red blood cells after they have entered the circulation.

Included in this group are the anemias resulting from hemorrhage, both acute and chronic, and those due to an abnormal destruction of red blood cells in the body either due (a) to some defect in the red blood cell itself as in familial forms of hemolytic types of jaundice, sickle cell anemia, etc., or (b) to some hemolytic agent present in the blood plasma, as in acute hemolytic infections due to streptococci, and in paroxysmal hemoglobinuria.

II. Those anemias in which there is a disturbance in the *formation* of red blood cells. This may be due to (a) developmental defects of the bone marrow; (b) toxic agents causing an inhibition of bone marrow function; (c) defective formation of red blood cells due to a deficiency of blood-building materials; or (d) myelophthisic conditions causing a quantitative decrease in the amount of functioning marrow.

CLINICAL CLASSIFICATION

In attempting to classify anemia clinically on the basis of etiology, it is of course obvious that certain clinical and laboratory criteria must be taken into consideration. In anemia, it is not always possible to obtain from the study of the patient any definite clue as to the etiologic factor. We must therefore learn to recognize through thorough history and physical examination certain factors which point to a possible etiology, such as achlorhydria; and we must learn also to recognize the results of the action of this etiologic factor upon the bone marrow.

HISTORY

The history obtained from the patient may hold the clue or clues which lead to a quick solution of the problem, and much attention should be given to getting a detailed account not only of the patient's symptoms but also of more remote data, such as occupation, diet, recent medication and familial tendency to blood disease. Among the complaints of the patient other than those due to anemia, careful questioning should be directed toward bringing out any evidence of chronic blood loss, chronic infection or lues. Indefinite symptoms

referable to the gastro-intestinal tract and to the central nervous system should take on added significance in the presence of anemia.

PHYSICAL EXAMINATION

The physical examination, which in any event should be complete, should particularly note the type of pallor, the state of nutrition of the body and the condition of the tongue, points which are sometimes too lightly passed over in the routine examination. Careful examination of the spleen and lymphnodes for enlargement, and the bones for tenderness are important in appraising the physical state of the hematopoietic organs. X-ray examination of the bones may sometimes solve an otherwise inexplicable blood picture by showing widespread bone marrow involvement by some neoplastic condition. The presence of pathology anywhere in the body which might serve as a possible source of blood loss or might contribute to malnutrition of the body, should be noted. Finally, physical evidence of slight neurological damage as may be obtained by testing the transmission of vibration through the tibia, the presence of a Babinski, or slight sensory disturbances should be ascertained.

The history and the physical examination give important clues which, when analyzed, may lead to a clinical diagnosis of the type of anemia even before any hematologic evidence is available; but this clinical diagnosis must be tentative, as the final criterion of diagnosis in anemia must of necessity be the hematologic and laboratory findings indicating as they do the condition of the blood and the state of physiologic activity in the bone marrow.

LABORATORY

The extent of the laboratory investigation of an anemia depends upon the complexity of the picture. In every case of anemia, the present condition of the blood should be determined through the agency of a complete blood count. The enumeration of the number of red blood cells per cubic millimeter of blood and the determination of the hemoglobin give information as to the degree or severity of the anemia.

Recent developments have shown that evidence of etiologic value can be deduced from a study of the average size, or rather volume, of the red blood cells; and from the concentration of hemoglobin in these cells. By the addition of a simple procedure to the routine technic of the blood count, i. e., the determination of the volume of cells in proportion to the plasma obtainable by the simple process of centrifuging a given volume of blood and noting this relationship, the volume and hemoglobin content of the individual cell can be estimated with a great degree of accuracy. (See Figure one.)

Wintrobe, in a large series of determinations on normal individuals, has found the normal range of mean corpuscular volume to be between eighty and ninety-four cubic microns, with an average of eighty-seven cubic microns.

The mean corpuscular hemoglobin is between twenty-seven and thirty-two micro-micrograms, the average being 29.5 micro-micrograms.

The hemoglobin concentration in the red blood cell normally averages about 33 per cent. On the basis of cell volume, he classified red blood cells as being normocytic, macrocytic, or

METHOD OF CALCULATION OF CORPUSCULAR CONSTANTS (Wintrobe)

$$\text{Mean Corpuscular Volume (C. V.) in cubic microns} = \frac{\text{Volume of packed red cells (in c.c. per 1000 c.c. blood)}}{\text{R. B. C. (in millions per c. mm.)}}$$

$$\text{Mean Corpuscular Hemoglobin (C. H.) in micro-micrograms} = \frac{\text{Hemoglobin (in gm. per 1000 c.c. blood)}}{\text{R. B. C. (in millions per c. mm.)}}$$

$$\text{Mean Corpuscular hemoglobin Concentration (C. C.) in per cent (\%)} = \frac{\text{Hemoglobin (gm. per 100 c.c. blood)}}{\text{Volume packed R. B. C. (c.c. per 100 c.c. blood)}}$$

FIGURE 2.—*Size and Hemoglobin Content of Erythrocytes in Various Types of Anemias*
(Wintrobe)

Type of Anemia	Mean Corp. Volume	Mean Corp. HBG.	Mean Corp. HBG. Concentration %	Mean Cell Diameter
Macrocytic	95-160	30-52	31-38	7.5-9.6
Normocytic	80- 94	27-32	33-38	6.7-8.0
Simple microcytic	72- 79	22-26	31-38	6.5-8.5
Hypochromic microcytic	50- 71	14-21	21-29	5.8-7.5

microcytic; and those cells in which the concentration of hemoglobin was below 30 per cent as hypochromic. (See Figure two.)

BONE MARROW

The next important hematologic fact to determine is the extent of involvement of the bone marrow. Does the etiologic factor act upon the red blood cell precursors alone? or does it involve all of the bone marrow structures? This very important point can be quickly determined through the count of the white blood cells, and the platelets.

A third factor of extreme importance is the state of functional activity of the bone marrow. Histologic studies have shown that the entire structure of the functioning bone marrow in man is in a relatively uniform state, and that there is within narrow limits a definite proportion of cells in various stages of development. Sabin has shown that there is a definite relationship between the physiological activity of the bone marrow and the peripheral blood picture which, in the normal, is evidenced by a rather fixed number of young, or reticulated red blood cells, in the peripheral blood. From the blood smear which should routinely be vitally stained with a solution of brilliant cresyl blue before the usual Wright stain is applied, valuable information concerning the functional activity of the bone marrow may be obtained through the recording of the presence and number of reticulocytes, nucleated red blood cells, myelocytes, etc.

With this hematologic data available, we may, from a laboratory standpoint, classify anemia as:

I. NORMOCYTIC
  A. INVOLVING RED CELLS PRIMARILY
    1. Regenerative
      a. Acute blood loss
      b. Increased blood destruction
        (1) Hemolytic anemias
        (2) Familial hemolytic jaundice
        (3) Sickle cell anemia
        (4) Lead poisoning
    2. Aregenerative
      a. Infection with toxic inhibition of marrow
  B. INVOLVING ALL BONE MARROW CONSTITUENTS
    1. Regenerative
    2. Aregenerative
      a. Benzol poisoning
      b. Arsphenamine poisoning
      c. Idiopathic aplastic anemia

II. MACROCYTIC
  A. RED CELLS PRIMARILY
    1. Regenerative
      a. Erythroblastosis
      b. Treatment phase of anemias due to deficiency of anti-anemic factor of Castle
    2. Aregenerative
      a. Addisonian pernicious anemia during stage of relapse or untreated
      b. Achrestic anemia
      c. Anemia associated with cirrhosis of the liver
        (1) So-called Banti's disease
  B. INVOLVING ALL BONE MARROW CONSTITUENTS
    1. Regenerative
      a. Erythroleucoblastosis
      b. Some stages of pernicious anemia
      c. Myelophthisic conditions
    2. Aregenerative
      a. Myelophthisic conditions with inhibition of marrow
      b. Radium poisoning

III. HYPOCHROMIC MICROCYTIC

A. INVOLVING RED CELLS PRIMARILY. ALL ANEMIAS IN WHICH THE CAUSE IS AN IRON DEFICIENCY EITHER DUE TO LOSS OF IRON STORES FROM THE BODY, DEFECTIVE UTILIZATION, OR ASSIMILATION OF IRON

1. Regenerative
   a. The above conditions under iron therapy

Aregenerative

   a. Above conditions with no iron supplied
   b. In the presence of infection even though treatment with iron may be going on

I shall discuss the various types of anemia briefly from a clinical and etiologic standpoint, and shall take up each group individually.

ANEMIAS DUE CHIEFLY TO BLOOD LOSS

Blood loss may be acute or chronic. The immediate symptoms of acute blood loss depend upon the rapidity with which the blood volume is reduced. When a patient has suffered an acute blood loss which occurs so rapidly that the body is unable to make up the loss of volume by immediate replacement with body fluids, symptoms of prostration, excessive thirst, rapid pulse, restlessness, and dyspnea occur; and if the blood volume is sufficiently reduced, death ensues.

The blood count in acute hemorrhage may be of very little significance, and even lull the physician into a false sense of security. Due to acutely lowered blood volume, there is a contraction of the vascular bed; and for several hours after the hemorrhage the blood count may show no marked diminution of hemoglobin or red blood cells per volume unit. I shall never forget the incident which first forcibly impressed this point on my mind.

A blood transfusion was requested for a woman who had suffered a marked post-partum hemorrhage. She was still on the obstetrical table and had evidently suffered a serious blood loss, as indicated by her physical condition. By the time we were ready for the transfusion, a blood count had been done and showed an 80 per cent hemoglobin, with about 4,000,000 red blood cells per cu. m. Because of this, the obstetrician cancelled the order for the transfusion. About three hours later, due to a persistence of symptoms of blood loss, another blood count was ordered, and showed a greatly reduced hemoglobin, necessitating immediate transfusion. This fall in hemoglobin was not due to additional bleeding, but to the replacement of the blood volume by tissue fluids with a dilution of the reduced volume of red cells.

Treatment in these cases should not wait for hematologic evidence of anemia, but immediate measures aimed at replacing blood volume should be instituted, preferably by blood transfusion; but if this is not feasible, by the administration of fluids into the circulation. Of course, the source of the bleeding should be controlled in order to prevent further loss of blood volume. After an acute blood loss there is a marked increase in the activity of the bone marrow which evidences itself in the blood smear by an increase in the reticulocyte count and recovery is fairly rapid.

Chronic blood loss produces an anemia quite in contrast to that of acute blood loss. Here, due to repeated loss of blood, there is finally an exhaustion of the reserve supply of iron; and the anemia becomes one due to iron deficiency, and shows the characteristics which will be discussed later with the other anemias of that type.

The diagnosis of this type of anemia depends upon a history of chronic hemorrhage such as occurs in recurrent menorrhagia or metrorrhagia, bleeding piles, etc., or upon laboratory evidence of bleeding as may be found in the stools or urine. The treatment of this type of anemia is obviously directed to the control of the source of bleeding and the replacement of the iron deficiency.

Increased blood destruction may be due to *extrinsic* factors, such as infection by hemolytic organisms, bacterial or parasitic invasion of the blood stream; chemical poisons such as carbon monoxide or lead; or it may be due to intrinsic factors such as congenital peculiarities of the red blood cells found in sickle cell anemia or hemolytic icterus of the congenital or acquired types; or conditions in which some

circulating hemolysin causes destruction of the red cells as in paroxysmal hemoglobinuria.

Clinical evidence of this process is to be had in the increase of bilirubin in the plasma of the blood, and in the stool. The spleen being an important organ of hematolysis, enlarges and may be clinically palpable. The diagnosis of increased blood destruction is confirmed by the laboratory findings of:

1. An anemia in which the blood cells are of normal volume and in which there is evidence of increased regenerative activity of the bone marrow indicated by numerous reticulocytes and sometimes by many nucleated red blood cells;
2. An increased icterus index or quantitative Van den Bergh;
3. Increase of bile pigments in the stool;
4. Increase of urobilinogen in the urine.

In the differential diagnostic study of an anemia in which it has been established that excessive blood destruction plays an important rôle, we must investigate all of the extrinsic and intrinsic factors capable of producing red cell destruction.

Infection may usually be easily discovered or suspected by the temperature reaction, the presence of a leucocytosis with a regenerative shift, positive blood culture, etc.

The possible relationships of *chemical poisons* depends upon the history of exposure and perhaps the finding of chemically bound hemoglobin, such as methemoglobinemia. Lead poisoning has the additional diagnostic feature of large numbers of stippled red blood cells due to the action of the lead on the reticulum of the young cells.

Investigation of the *red blood cells* themselves for inherent defects often gives valuable diagnostic information. Sickling of the red cells is the pathognomonic feature of sickle cell anemia. Increased fragility of the red blood cells as measured by their resistance to hypotonic salt solution is characteristically found in the congenital and acquired forms of familial hemolytic jaundice.

ANEMIAS IN WHICH THERE IS A DISTURBANCE OF RED BLOOD CELL FORMATION

Anemias Due to Deficiency of Blood Building Materials.—The study of erythrogenesis has received an added impetus due to the fundamental researches of Whipple, Minot, and Castle. These investigators have shown that, in order for the adult red blood cell to develop normally through the stages of megaloblast, erythroblast, normoblast and reticulocyte, certain blood building materials must be supplied. Deficiency of these substances lead to developmental defects in the red blood cell which may be recognized hematologically and through these hematologic characteristics point to the missing factor.

Iron Deficiency (hypochromic anemias).—It has been known for a long time that iron is necessary for the proper formation of hemoglobin in the body. Under certain conditions, a lack of this important blood building substance occurs. Deficiency in iron may be due to such simple causes as insufficient intake of iron in the diet as may occur in people who undertake deficiency diets, such as a milk diet for the reduction of weight; or who, due to economic conditions, are of necessity on a deficient diet. It may also be due to mechanical blood loss in which the iron in the red cells escapes from the body, especially in cases of chronic bleeding where the reserve stores of iron become depleted. Recently attention has been drawn to the gastro-intestinal tract as an important factor in iron metabolism. With a decrease or absence of free hydrochloric acid in the stomach, due to some defect in secretion, the nature of which is still little understood, there is an interference with the absorption of iron. Certain toxic states, such as chronic nephritis, in some manner, also disturb the absorption or utilization of iron. Regardless of which of the above factors exists, the resulting deficiency causes a disturbance in red blood cell production which is manifested clinically by an anemia, and is characterized hematologically by the presence of red blood cells deficient in hemoglobin (hypochromic), and usually smaller than normal (microcytic).

While all the hypochromic anemias are etiologically related and show a blood picture characterized by the lack of hemoglobin, nevertheless certain types of clinical syndromes are recognized which make it advisable to classify the hypochromic anemias from this standpoint even

though they cannot be differentiated etiologically or hematologically.

Therapeutically, the hypochromic anemias are all amenable to treatment with iron, giving further weight to the probability of their etiologic identity.

Idiopathic hypochromic anemia is a clinical syndrome which has been discussed in the literature under various headings, such as primary microcytic anemia, simple achlorhydric anemia and chronic chlorosis. It occurs almost exclusively in women, although a few cases have been reported in men; and I have personally seen one case in a man in which the entire picture was indistinguishable from the condition as found in women. Most of the cases occur in the child-bearing period of life, especially in the latter part of this period and particularly in those women who have borne children. It has been suggested that the physiologic demands for iron due to pregnancy and menstruation have not been supplied in the diets of these women, who are usually in the poorer classes, or have gone through long periods of diet for weight reduction.

The onset is insidious and the patient usually gives a history of chronic invalidism which extends over a period of years. The history is vague and such symptoms as weakness, easy fatigability, loss of appetite, shortness of breath on slight exertion, and digestive disturbances of an indefinite nature have often led to a diagnosis of neurasthenia. However, certain diagnostic features make this disease easy of recognition if the physician is aware of the existence of this condition. In addition to the symptoms referable to the anemia, these patients all complain of digestive disturbances based upon an absence of hydrochloric acid. Atrophy of the papillae of the tongue, usually without the characteristic history of periodic soreness obtained in pernicious anemia, is a frequent finding. A defect of the nails consisting of hollowed, brittle, tender nails resembling a spoon deformity is considered by some authors as almost pathognomonic. The diagnosis of idiopathic hypochromic anemia depends upon the finding of a hypochromic microcytic anemia in the absence of signs of increased blood destruction and with the absence of significant changes of the leucocytes in a chronically ill person with an achlorhydria and spoon nails.

While there are many points of similarity between idiopathic hypochromic anemia and pernicious anemia clinically, they can readily be differentiated hematologically. Iron in large doses is just as specific for this condition as is liver in pernicious anemia. The treatment should be continued for a long period of time, as relapses occur if the iron is discontinued.

A variation of this condition with dysphagia (difficulty in swallowing) as the initial and perhaps predominating symptom but otherwise entirely similar in every respect to idiopathic hypochromic anemia, has been described and is known as the Plummer-Vinson syndrome.

Hypochromic anemia of pregnancy is another variant of idiopathic hypochromic anemia appearing about the middle of pregnancy, and presenting the clinical and hematologic features of idiopathic hypochromic anemia. It is significant that most of these cases have occurred in women who were well on in their child-bearing period, and had had five or six previous deliveries, suggesting an exhaustion of iron stores.

Chlorosis is another form of hypochromic anemia which deserves individual mention. It usually becomes apparent soon after the establishment of menstruation and is rarely seen after adolescence. The symptoms are those of anemia with some disturbance of menstruation. Vague gastro-intestinal symptoms are common. Physical examination shows nothing peculiar to this condition, with the possible exception of a greenish pallor. Achlorhydria is rare and gastric hyperacidity common. The blood picture is characteristic of an iron deficiency anemia. During the phase of recovery there is sometimes an abnormal increase in the blood platelets which may complicate the clinical course of the disease through the occurrence of a thrombosis of some important vessel. In common with the other hypochromic anemias, chlorosis responds to iron therapy.

There is a variety of other conditions including many of the large group formerly classed as the secondary anemias, in which the ultimate anemia is due to iron deficiency, and is characterized by hypochromia. Chief among

these are chronic blood loss; and diseases of the gastro-intestinal tract, especially those associated with diarrheas or interfering with the absorption of food products, intestinal parasites and cachectic diseases.

DEFICIENCY OF ANTI-ANEMIC SUBSTANCES OF CASTLE AND VITAMIN B_2 (MACROCYTIC ANEMIAS)

Based on the fundamental research of Whipple, two observers—Minot and Murphy—in 1926, initiated the use of liver in the treatment of pernicious anemia, and showed that by its use, they were able to cause a rapid maturation of the megaloblasts which crowded the bone marrow during the stage of relapse. Cohn, in 1927, studied the constituents of the liver and found that a water soluble-alcohol insoluble portion, which he labeled fraction "G", was responsible for this stimulus to maturation.

Castle, in 1929, impressed by the relationship of achylia gastrica to pernicious anemia, in a series of brilliant experiments showed that there were two factors in digestion which influenced hematopoiesis. The first, which he called the *intrinsic* factor, was an active constituent of the normal gastric contents, in all probability secreted by the gastric mucosa. This substance, which he showed was not hydrochloric acid or pepsin, was capable of reacting with *protein* matter (extrinsic factor) with the production of a substance which, when administered to pernicious anemia patients, gave a marked hematopoietic response, such as obtained by the feeding of liver and of fraction "G". More recently, Morris and his co-workers have demonstrated that normal gastric juice, when concentrated and given intramuscularly in adequate amounts, cause an immediate remarkable reticulocyte response. On the basis of their experiments, they believe that normal gastric juice contains an hematopoietic hormone for which they propose the name of "addisin". A deficiency of this substance, which is usually referred to as the anti-anemic substance of Castle, apparently is responsible for a lack of maturation of the megaloblasts and is evidenced by the presence in the peripheral blood of large red blood cells (macrocytes). Where there is a deficiency of iron associated with a lack of the anti-anemia factor of Castle, the resulting red blood cells would be both macrocytic and hypochromic.

Deficiency in vitamin B_2 has been advanced as another cause of macrocytic anemia but inasmuch as this vitamin is present in many of the foods which have been shown to contain the extrinsic factor of Castle's anti-anemic substance, it is probable that future studies may identify the extrinsic factor as a part of the vitamin B complex.

All of the members of the group of macrocytic anemias have certain things in common, which, as in the case of the hypochromic anemias, seem to give them etiologic identity even though they occur under a wide variety of conditions. *Clinically,* they all show a distribution of lesions involving the gastro-intestinal tract, the central nervous system, and the bone marrow. *Hematologically,* they are all characterized by an increase in the average volume of the red blood cells, a high color index and a hyperplastic bone marrow. *Therapeutically,* they all react favorably to the administration of the anti-anemic substance of Castle.

Addisonian pernicious anemia, which before the introduction of adequate treatment, was characterized by its eventual progression through stages of relapse and remission to a fatal termination, is the typical example of this type of anemia. Pernicious anemia is a disease involving chiefly adults over forty. Its onset is insidious, but the patient usually consults a physician within the first year after the onset. In addition to the usual symptoms common to any anemia, there are complaints which refer specifically to the gastro-intestinal tract, and the central nervous system. Periodic recurrent sore tongue occurs usually early in the course of the disease, and is accompanied by a history of gastro-intestinal trouble described as a chronic indigestion, or mild dyspepsia, with perhaps diarrhea and occasional vomiting. In a number of cases the first symptoms complained of may be of nervous origin, such as symmetrical parasthesiae of the feet or hands.

Physical examination also shows several significant features. Extreme pallor of a lemon-yellow color, with little or no loss of weight, is diagnostically important. Glossitis or atrophy

of the tongue is usually present. Slight enlargement of the spleen is typical. Loss of vibratory transmission at the ankles, slight sensory disturbances, and the presence of a Babinski are signs indicating involvement of the nervous system and may be present before there are any hematological evidences of the condition.

Achylia gastrica, which is total and absolute, resisting even the alcohol histamine technic for producing gastric secretion as described by Bloomfield, is always present and may exist for many years before the anemia is clinically apparent. These clinical factors are so prominent a part of the picture of pernicious anemia that, when they occur, the diagnosis may almost be certain clinically before hematologic confirmation.

Sprue, which is also characterized by a macrocytic anemia, is common in tropical countries where there is a scarcity of meat, vegetables, and dairy products, substances which have been shown to contain the extrinsic factor of Castle. It frequently occurs also in cases associated with chronic affections of the gastrointestinal tract, such as chronic alcoholic gastritis and diarrheal conditions which may influence the production or absorption of nutritional substances. The symptoms and physical signs resemble those of pernicious anemia except that as the disease progresses, the diarrhea becomes so severe as to cause extreme loss of weight and an appearance of cachexia. A calcium deficiency resulting in tetanic symptoms may also follow the diarrhea. The blood picture and bone marrow findings are indistinguishable from those of pernicious anemia.

Pernicious Anemia of Pregnancy.—An anemia occurring during pregnancy, and due to a temporary suppression of the intrinsic factor, has lately appeared in the literature. It is characteristic of this condition that it develops only during pregnancy, and disappears immediately upon the termination of the pregnancy. The temporary absence of the anti-anemic factor is claimed by Wintrobe to be due to the withdrawal of this substance by the fetus in order to stimulate its own cell production. The blood picture is identical with that of pernicious anemia, and the condition responds to liver therapy.

Occasional *macrocytic anemias* have been reported in which the anemia is associated with a normal gastric acidity in the absence of digestive or nervous system changes. This condition does not always react to liver therapy, and little is known as to its cause. It has been reported under the name of "Achrestic anemia".

Anemia associated with *cirrhosis of the liver* has been described. It resembles pernicious anemia in many respects. It is noted chiefly in cases of Laennec's cirrhosis, and is usually associated with an enlargement of the spleen. Hematologically, because of evidence of a regenerative type of marrow, as indicated by an elevation of reticulocytes and an increase in bilirubin in the blood, it can be considered, in part at least, as a result of increased blood destruction. This is further borne out by the marked hemosiderosis (iron from destroyed red cells) of the organs histologically. On the other hand, the presence of a leukopenia, and the reticulocyte response during improvement, suggest a mechanism similar to that in pernicious anemia. Wintrobe concludes that this condition is related to pernicious anemia, and explains the mechanism as a lack of storage of the anti-anemic substances by the diseased organ. He substantiates this by pointing out the response of this type of anemia to liver therapy.

Splenic Anemia—Banti's Disease.—It is doubtful whether splenic anemia or Banti's disease is a clinical entity. It has been shown that cirrhosis of the liver with secondary enlargement of the spleen due to chronic passive congestion cause changes identitcal with that characteristic of Banti's disease. The anemia which is responsible for the term splenic anemia is similar to that produced by cirrhosis of the liver as described above and is associated with leukopenia and sometimes thrombocytopenia. The association of this type of anemia with an enlargement of the spleen has been shown to occur in other disorders of hematopoiesis, such as aleukemic or leukopenic leukemia, and splenic Hodgkin's disease.

Recently a patient presenting history of chronic illness with an enlarged spleen and liver and a

blood picture of leukopenia, anemia, and thrombocytopenia, came to our attention. His history dates back over a period of several years of digestive disturbances. During the course of the disease, the patient developed a jaundice, and some ascites, and progressed along the typical course as described by Banti. Diagnosis of splenic anemia was made. At autopsy, examination showed an enlarged, rather fleshy spleen and a red, hyperplastic bone marrow. Microscopic examination showed the typical findings of a panmyelosis characteristic of leukemia, the final diagnosis being aleukemic leukemia. It is probable that with a greater appreciation of the causes of leukopenic states associated with anemia that more of these cases will be properly catalogued and splenic anemia eventually be taken out of the classification of anemias.

Certain toxic substances, when absorbed by the body, interfere with normal blood formation through *inhibiting the normal function of the bone marrow.* Thus, while blood cells are being lost through senesence at the normal rate, new cells are not being formed to replace them. This inhibitory effect is not related to any deficiency or lack of availability of blood building materials, as is shown by the condition of the peripheral blood cells. These are neither macrocytic nor hypochromic, but are of normal size and hemoglobin content; i. e., normocytic and normochromic. Within a short time, depending upon the degree of inhibition of marrow function, the blood picture in these cases becomes typical of aplastic anemia, showing a marked reduction of all of the cellular elements produced by the marrow. Hematologically, the picture is that of a normocytic, normochromic anemia with little or no evidence of regeneration, a leukopenia and a thrombocytopenia.

Among the chief causes of this type of anemia are chronic *benzol and arspenhamine poisoning.* The symptoms of this condition are those of a progressive anemia of the aplastic type with purpura due to the marked thrombopenia. The differential diagnosis of this condition from idiopathic chronic aplastic anemia, which we will duscuss later, may be impossible without a knowledge of the exposure of the patient to these poisons.

Chronic infection also exerts an inhibiting influence on the bone marrow. The anemia in this condition is usually due to two factors, one of blood destruction and the other of marrow inhibition. We therefore see a mixed blood picture in which the cells are microcytic and hypochromic, and at the same time there are few or no reticulocytes, an aregenerative picture. There may also be some depression of the leucocytes, but rarely do we find the severe picture seen in benzol poisoning.

It is extremely important to note that chronic infection during the course of a deficiency anemia may so alter the response to treatment that we may become suspicious of a mistake in diagnosis. If in the treatment of a macrocytic anemia with liver, or a hypochromic anemia with iron, we do not get the looked-for reticulocyte response, we must carefully eliminated focal infection. Whipple has definitely shown that iron may be ineffectual in hypochromic anemia in the presence of infection. Robertson has noted, during the treatment of a case of Addisonian pernicious anemia with liver, an interruption of bone marrow response due to intercurrent infection.

The effect of x-ray upon the bone marrow is chiefly directed to the leucocytes. During ordinary exposures used for treatment, anemia does not result; and when it is present is usually the result of the disease requiring the irradiation rather than the effect of the x-ray. In fact, small doses of x-ray at first stimulate red blood cell production. However, prolonged and repeated exposure such as may result from careless operation of x-ray machines, may terminate in an eventual bone marrow picture such as we see in the absorption of radio-active substances.

Our knowledge of the effect of *radium and radio-active substances* is due to the original observations of Martland. In non-lethal dosages, there is at first a period of stimulation in which there is an increase of the red blood cells. In some of the patients examined in the early stages of radium poisoning, the red cells were over 6,000,000 per cu. mm. Later, there is an exhaustion of the bone marrow and a severe anemia characterized by macrocytic red blood cells, and leukopenia, a leukopenic anemia of the pernicious type. The bone marrow up to within a short time of the termination shows a picture similar to that seen in pernicious anemia, indicating that the aplastic blood picture is due to a physiologic aplasia rather than an anatomic loss of structure in the bone marrow.

MYELOPHTHISIC CONDITIONS CAUSING A QUANTITATIVE DIMINUTION OF THE FUNCTIONING MARROW

Included in this group are those conditions which, by their development, encroach more and more upon the marrow space, destroying and crowding the functioning bone marrow, but, as has been shown by Piney, leaving here and there intact islands of marrow capable of responding to increased functional demands. Examination of the bone marrow in these conditions shows these islands of myeloid tissue to be extremely hyperplastic. The blood picture, therefore, is that of a severe anemia with evidence of intense bone marrow activity as shown by the presence of many nucleated red blood cells, reticulocytes, and occasional myelocytes.

A frequent diagnostic error is the interpretation of this severe anemia and attendant leukopenia as a form of pernicious anemia. However, careful study of the clinical and hematologic findings will usually present some basis for differentiating these conditions. One of the features of myelophthisic anemia is the presence of a disproportionately large number of nucleated red blood cells as compared to the number of reticulocytes.

The differential diagnosis of the type of tissue encroaching upon the bone marrow is usually based upon the presence of other clinical data, such as the known presence of a carcinoma, x-ray picture showing multiple bone involvement in multiple myeloma, evidence of disturbance of lipoid metabolism in the xanthomatoses, and the finding of some evidence of leukemia in the blood smears. There may, however, be certain cases in which, in spite of all clinical efforts, the diagnosis remains obscure. In this event, bone marrow biopsy should clear up the diagnosis.

DEVELOPMENTAL DEFECTS OF THE BLOOD-FORMING ORGANS

In all of the preceding types of anemia it has been possible to explain the mechanism involved, at least in many of its important aspects. The etiologic factors have been more or less clear-cut.

We now come to a group of conditions which are still unexplainable on the basis of present-day knowledge and for which there has not been discovered any cause other than perhaps a developmental defect of hematopoiesis.

THE ERYTHROBLASTOSES

Under this heading have been grouped a series of conditions which, while apparently showing different clinical pictures, are similar in their hematologic and histologic manifestations. They occur probably much more frequently than recorded, chiefly because they are not as yet generally recognized. The conditions usually classified as erythroblastosis are: (1) Congenital hydrops; (2) icterus gravis; (3) anemia of the newborn. Because of the identical blood picture and the histologic findings of extra-medullary hematopoiesis (blood formation), I recently suggested the addition to this group of a fourth clinical variety known as "erythroblastic anemia", or "Cooley's anemia".

All of these conditions are essentially congenital. There is a tendency to occur in more than one member of the same family. They all show an anemia, with immature and nucleated red blood cells in the peripheral blood. In all of these conditions, the spleen is enlarged; and histologically there is found marked extramedullary hematopoiesis. It may be etiologically significant that practically all cases of erythroblastosis, regardless of type, occur in the children of women who, at the time of birth, were well advanced in their child-bearing period, nearly all being over thirty years of age and many of them past thirty-five. Usually the first and second children are spared, most of the cases occurring in multiparous women in their later pregnancies.

ERYTHROBLASTOSIS—TYPE: CONGENITAL HYDROPS

This disease occurs most frequently in premature fetuses who are usually stillborn, although many of them are born alive and die within a few hours of birth. Hydramnion is frequently present, together with edema of the placenta. Occasional cases have been reported in which there was slight or moderate jaundice or anemia associated with the edema. The edema usually takes the form of a complete

anasarca, but may be limited to the pleural or peritoneal cavities. The liver and spleen are enlarged, and histologic examination shows marked evidence of extramedullary hematopoiesis in the liver, spleen, lymphnodes, and sometimes other organs. Smears of the peripheral blood taken at autopsy show large numbers of nucleated red blood cells.

ERYTHROBLASTOSIS—TYPE: ICTERUS GRAVIS

Clinically, icterus gravis is readily differentiated from icterus neonatorum by the fact that in icterus gravis the icterus is present at birth, or develops within a few hours after birth and progresses rapidly, usually to a fatal termination. Frequently attention is called to the intrauterine development of the jaundice by the finding of a yellow vernix caseosa. The first and second born frequently escape, and then there may be a definite occurrence of icterus in successive pregnancies. Physical examination reveals, in addition to the jaundice, a more or less severe degree of anemia with slight to moderate enlargement of the liver, and usually a marked enlargement of the spleen. Petechial and ecchymotic hemorrhages are frequently noted in the skin and mucous membranes. The blood count shows a macrocytic anemia with many nucleated red cells, and some immature leucocytes in the smear.

As the disease progresses, the jaundice becomes increasingly intense, the child shows a marked apathy, becomes drowsy and usually dies in convulsions. A few cases, apparently icterus gravis, do well in spite of the severe jaundice, and after a period of several weeks to several months the jaundice disappears and the blood returns to normal. These cases appear to be a transition between icterus gravis and anemia of the newborn, in which jaundice may also be a predominant factor. Necropsy shows, in addition to the effects of the jaundice, histologic findings similar to those in congenital hydrops.

ERYTHROBLASTOSIS—TYPE: ANEMIA OF THE NEWBORN

In recent years, a small group of cases have appeared in the literature in which an otherwise apparently normal infant was born showing a marked pallor or developed a marked pallor within a few days or weeks after birth. These children were born of normal parents with no clinical or laboratory evidence of lues or other transmissible disease. There was a familial tendency toward newborn disease in many of the cases reported. In about 50 per cent of the cases, mild jaundice was present. Physical examination showed no gross abnormality except for the extreme pallor, and, in about 60 per cent of the cases, a palpable spleen which was not remarkably enlarged. The blood picture showed a marked to severe macrocytic anemia in which a few normoblasts were present, although they did not form as striking a part of the picture as in the previous conditions. The course of the disease was usually benign and recovery complete in a few months to a year. Death, however, has occurred in this condition, and can be prognosticated by the appearance of large numbers of nucleated red blood cells in the peripheral circulation.

ERYTHROBLASTOSIS—TYPE: ERYTHROBLASTIC ANEMIA

The chief difference in the history of this condition is the fact that the disease has a racial incidence among Mediterranean peoples. Up to the present time, no single proved case has been reported outside of this group. The onset of the disease suggests a congenital origin. The first symptom, usually pallor, has been reported as being present since birth, and may not be noted until as late as nine years after birth. Following the appearance of the pallor, the disease progresses gradually and the patient assumes a typical appearance which Cooley has called "Mongoloid". Rather characteristic changes occur in the bones, which may be detected roentgenographically. The blood picture is that of a moderately severe anemia with a large number of immature and nucleated red cells in the smear. A rather characteristic thing about this type of anemia is that following splenectomy, there is an increase in the erythroblastemia, which is persistent and constant, having been noted as long as fifteen years after splenectomy. The course is progressive with fatal termination within a few years, due to the secondary changes provoked by the pro-

longed secondary anemia or to intercurrent infection.

Inhibition of development of the hematopoietic organs with persistence of fetal type of blood formation, possibly on the basis of an inadequate supply of blood building materials, appears to be the logical explanation. Whether this is due to defective transfer or absorption of these materials from the mother to the child, or to an actual deficiency of these substances in the mother, as is the case in the anemias of pregnancy, cannot be stated. The similarity of the bone marrow picture in erythroblastosis to that found in pernicious anemia during relapse adds plausibility to this supposition.

IDIOPATHIC APLASTIC ANEMIA

Idiopathic aplastic anemia has been described in the acute and chronic forms. In the acute form, it is a rapidly fatal disease usually affecting young adults, and is associated with a high fever and oral sepsis such as is seen in some of the acute leukopenic states. The blood count shows a normocytic anemia with leukopenia and thrombopenia.

The chronic form shows a similar blood picture which develops more progressively. In both, the picture is that of a depressed bone marrow activity. Future studies, especially with bone marrow investigation, will undoubtedly place many of these so-called aplastic anemias into one of the known causes of panmyelophthisis, such as malignant neutropenia, leukopenic leukemia, etc.

PROGRESS IN DIAGNOSTIC METHODS

A clearer understanding of the anemias has resulted due to several factors. The epochal researches leading to the knowledge of nutritional deficiencies of the bone marrow and their effect upon blood formation have opened up an entirely new concept of anemia and its treatment. The influence of the gastro-intestinal tract upon blood formation through a direct hormonal stimulation is another recent advance in our knowledge of this subject. More accurate methods of examination of the blood and a better understanding of bone marrow physiology have also helped in a more accurate interpretation of the hematologic evidence. The availability of bone marrow for study during life through the perfection of simple biopsy and puncture technics has also aided in corelating the blood picture with the actual state of the marrow. All of these have contributed to a broader concept of hematopoiesis and disturbances of its normal and orderly processes.

A careful study of any given case of anemia in an orderly and systematic manner, including detailed history, careful physical examination, and thorough hematologic and laboratory study of the condition of the blood and the state of the bone marrow by the methods described above should, in most instances, lead to a proper classification of the type of anemia dealt with.

There are, however, a small group of cases, especially those in which the anemia is associated with leukopenia and thrombocytopenia, where serious diagnostic difficulty may be encountered. Frequently, the predominance of symptoms usually associated with one particular cell type catches the imagination and fancy of the diagnostician, and perfectly logical errors in diagnosis occur.

A patient was admitted to the hospital with predominating symptoms of bleeding from the mucous membranes and ecchymotic hemorrhages in the skin. The blood count showed a severe anemia, a leukopenia, and a marked thrombocytopenia. The clinical diagnosis of thrombocytopenic purpura hemorrhagica was shown at autopsy to be in error, as the examination of the bone marrow showed a leukemic infiltration.

The aregenerative blood picture is explainable on the basis that sometimes, in myelophthisic conditions of the bone marrow, the invading tissue exerts an inhibiting effect on the surrounding bone marrow. In other cases, the anemia and leukopenia are associated with symptoms depending upon the granulopenia; i. e., oral sepsis, high temperature, ulcerations of the mucous membranes, etc. The diagnosis of agranulocytosis is made and at autopsy or by marrow biopsy the condition is shown to be due to some factor causing a panmyelophthisis with inhibition of the entire marrow, or, in many instances, a leukemia in the aleukemic or leukopenic stage.

LUES

A frequent error occurs in the diagnosis of an anemia caused by lues, giving the typical clinical and laboratory findings of Addisonian pernicious anemia. On the wards at the City Hospital, I have seen patients, frequently colored, with serologic lues which hematologically could not be distinguished from pernicious anemia, and who, on anti-luetic treatment, clear up entirely even without liver. It is probable that lues inhibits the formation of the anti-anemic factor of Castle, or in some way makes it unavailable for use.

I wish to emphasize before closing the importance of recognizing the deficiency types of anemia chiefly because, with the proper diagnosis, treatment is almost miraculous in clearing up the condition.

SUPRARENAL GLAND IN THE TREATMENT OF GLAUCOMA, PROGRESSIVE MYOPIA, AND SOME ALLERGIC CONDITIONS

By SHERWIN LIVINGSTON HASELTINE, M.D., Elizabeth, N. J.

Read before the Section of Eye, Ear, Nose and Throat at the Annual Meeting of The Medical Society of New Jersey, April 28, 1937.

Glaucoma is one of the most dreaded of eye conditions, because its end results are blindness; hence it has occupied the interest of ophthalmologists for years.

Two years ago my work in this field started on a theory that glaucoma was possibly caused by a deficiency of the hormone of the suprarenal gland.

As very little has been written upon this subject, work at first was in the dark, but by working on a number of cases I have found that the hormone of the cortex serves to render the walls of the capillaries and vessels less permeable to the water of the plasma of the blood. In its absence then, the tissues become concentrated with water, while the blood pressure is reduced by its loss. This is borne out by the work of Swingle, Pfeffner [1] and Josephson.[2]

In view of the above findings, it is logical to believe that vessels of the retina and choroid with permeable walls would lead to increased pressure within the eyeball. If we can find a remedy that will make the vessel walls less permeable, the tension can be reduced in glaucoma by relieving the edema of the cribiform plate and give free drainage to the eye.

In research work it was found that the cortex of the adrenal was very potent; but by using the madella as well, its action is increased. Therefore the recommendation of the use of the whole gland extract. Stewart and Rogoff state that the cortex is very potent alone [3]; Armour in experimental work has shown that the medella causes a great reduction in blood pressure.

Glaucoma is possibly a disfunction of the endocrines, as is shown by cures with polyglandular therapy. This is borne out by the findings of Kruch and Farina.[4] The fact is that single glandular extracts give definite results in certain diseases, and Hans Schroeder [5] states this to be in conformity with his findings. The administration of suprarenal gland lowering tension is borne out by Howell [6] as well.

Five patients with glaucoma, who were at an apparent standstill with the use of myotics and dionin, had a marked decrease in the intraocular pressure with the addition of suprarenal gland to the treatment. In addition to the care of the glaucomatus eye it has been the custom to treat the nose and throat as well.

It seems probable that progressive myopia and simple glaucoma are of similar origin, differing in their manifestations because of the differences in the elasticity of the tissues of the eye,—the more elastic and distensible eye stretching into a myotic state, and the less elastic yielding at the optic nerve head.

Improvement both mentally and physically has been noted in five cases in the field of progressive myopia. This physical improvement in turn will give tone to the fibers of the sclera, thus arresting the progress of the myopia. E. M. Josephson [7] holds the same opinion.

In passing, it might be interesting to note that impairment of hearing, associated with glaucoma, was improved by the administration of suprarenal gland. Dr. Somers [8] got the same results with the use of cortin. Armour and company have proven the above on animals in their laboratory. The permeable vessel walls on the closed middle and inner ear would increase the tension in the inner ear and cause nerve deafness or nerve block, while in the middle ear it would interfere with the movements of the ossicles.

To my surprise, in the second glaucoma case, where the glandular treatment was used, the patient said that the new remedy had stopped her hay fever. After the fourth powder, her hay fever symptoms ceased and did not return, also the tension in the eye was gradually brought down to normal.

Hay fever and asthma are usually associated with some disfunction, such as abnormalities in the nose, rhinitis, polypi, and sinusitis. Chronic, focal or systemic infections must not be overlooked in searching for the cause.

Dr. Hurd [9] states, "That the chronic infections of the sinuses are primarily due to bacteria, poor drainage, and aeration, should be modified". He adds, "It is due to a deranged mucous membrane caused by one of three factors, namely: (a) Deficiency in vitamins, (b) allergy, or (c) endocrine imbalance." Hollander [10] also concurs with the above findings.

In working with asthma patients it was noted they began to show improvement in from forty-eight to seventy-two hours under this treatment; and Dr. Orville Barbour [11] observed 278 acute asthmatic attacks in 112 infants and children that were relieved by administering the whole suprarenal gland extract. Drs. F. M. and R. T. Potenger [11] treated nineteen children and nine adults for asthma and got good results.

In a number of allergic eczema cases, marked improvement was noted within forty-eight to seventy-two hours. These cases were all of allergic origin and recurred at intervals. Dr. Barbour [11] states he has seen improvement with the use of suprarenal gland in this type of case.

Swingle [12] says, "That the action of adrenal cortex is mysterious". "And so it is," states Loeb.[13]

The essayist has found a great many different conditions that have responded definitely to the treatment by the whole suprarenal gland.

The mode of treatment that has served best is by mouth, as it avoids the possible toxic effect of contaminating substances. I have been giving from one-eighth to one-quarter grain doses of the powdered extract before meals.

In over two hundred cases of hay fever, asthma, and allied symptoms, treated with suprarenal gland, the results have been gratifying. It is advisable to treat the nose and throat as well as care for any conservative surgery that is necessary.

In conclusion, I wish to emphasize the fact that the use of suprarenal gland has caused the following:

1. The vessel walls to be less permeable, thus reducing the tension in glaucoma.
2. Relieving of allergic conditions as: (a) Hay fever, (b) asthma, (c) vernal catarrh, and (d) eczema.
3. Arrest of progressive myopia.

This work is just begun, and it is necessary to do further research work by all of us and have it checked by others.

Case 1. T. C. has had a persistent vernal catarrh of the eyes of twelve years' standing. On April 3rd, 1936, the follicles resembled trachoma. The eyes had been rubbed and operated upon several times before and it still persisted. The eyes were treated locally and suprarenal gland extract in ¼ grain doses t. i. d. (There are no scars on the cornea.)

April 17th, 1936, eyes do not look so red. June 26th, follicles in right upper lid are almost gone near the margin, those in the left upper lid were small at the margin but large at the fornix.

Case 2. Mrs. C. C. has had a conjunctivitis and eczema around the eyes for two weeks three times a year for the past five years. June 3rd, 1936, edema and eczema around the eyes for several days. Nasal membranes are pale and grayish looking. Nasal tampons and extract of suprarenal gland given three times a day. June 5th, redness around the eyes gone and she stated, "It was gone last night." Argyrol tampons caused a redness to reappear around the eyes. June 8th, no redness around the eyes and nasal membranes a normal pink. Argyrol tampons did not produce the redness around the eyes today.

Case 3. Miss Cr. has had hay fever for ten years, and the last two she has had asthma as well. July 20th, 1936, the nose was stopped up and she was wheezing. The nose and throat were treated

and extract of suprarenal gland given. July 24th, no headaches and not so much mucous in the chest. July 27th, head a little full today, so cut down on dose of extract. Aug. 3rd, head clearer, nose open and less congestion. August 10th, 1936, head clear and chest normal.

Case 4. A. T. August 21st, 1935, hay fever for last few days. Had submucous last year. Nasal treatment and gland therapy. August 28th, 1935, notices an improvement, not so much discharge from the nose and eyes, head clearer. August 31st, nose doesn't discharge much. September 4th, 1935, no discharge from the nose.

Case 5. C. L. September 9th, 1936, hay fever, nasal membranes pale and swollen, sneezes a great deal and eyes water. Treated nose and throat and gland therapy. September 11th, doesn't sneeze as much and eyes do not water. September 30th, membranes not so pale, powders given b. i. d. October 8th, 1936, powders once a day and nose more open. October 15th, 1936, nasal membranes pink and discharge from nose thick; powders then given every other day for a week.

Case 6. R. K. April 25th, 1932. Eyes always run, headaches, conjunctivitis and hypertrophic rhinitis. Deflected septum to the left, frontals and antri dull to illumination. His eyes were under treatment off and on until August, 1933, with no marked improvement. He had had a submucous resection. August 22nd, 1936, he returned complaining of his original symptoms, but the nasal membranes looked grayish. The nose was treated and extract of suprarenal gland given (t. i. d. for a week and b. i. d. for the next week). On January 27th, 1937, I saw him and his nasal membranes were normal pink. He stated three days after he took the powders he felt better but continued with them for two weeks when he was relieved.

Case 7. M. T. August 25th, 1934. Glaucoma simplex tension markedly increased in each eye. Was under usual treatment until December 8th, 1934, when tension was normal. May 4th, 1936, both eyes red and paining. Tension markedly increased. Eserine and dionin given. May 11th, tension still increased then suprarenal gland given in conjunction with the above. May 24th, 1935, the tension was normal.

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RECENT ADVANCES IN VERNAL CONJUNCTIVITIS

LOUIS LEHRFELD, A.M., M.D., Philadelphia, Pa.
Attending Surgeon, Wills Hospital, Philadelphia

Read before the Section on Eye, Ear, Nose and Throat at the Annual Meeting of The Medical Society of New Jersey, on April 28, 1937, and demonstrated with motion pictures in color.

Beginning early in April and continuing throughout the spring and summer months, there occurs in this part of the country a disease of the eyes in children and in young adults, commonly known as *vernal conjunctivitis.* It is an ocular manifestation of an allergy. The principal symptoms are itching, hyperemia, and lacrimation.

There are two types of this periodic ocular disorder. One manifests itself as an urticarial-like, or phlyctenular-like vesiculation, occurring only at the limbus, there being one, two, three, or more blebs at the limbus, either discreet or confluent, at the onset of the disease; or as a frosting effect at the limbus in a small arc and large arc, or involving the whole circumference of the limbus.

The second type is known as the lid form in which the conjunctival surface of the lids, principally the upper, exhibits a simple follicular conjunctivitis, or in the advanced stage after several seasonal attacks, manifests itself as a cobblestone paving, or in the more advanced stage as a giant granuloma.

The limbic type and the lid type are never seen in the same eye. The negro always manifests but one type, namely the limbic.

SEASONAL OCCURRENCE

This disease begins in the early spring, sometimes in the late spring, and corresponds with

the time of the pollenation of trees and grasses. The disease never has its initial onset in the late summer, or in the fall, or winter. The limbic type is self-limiting in that recovery takes place both symptomatically and pathologically with the approach of cold weather. There are instances in which the disease lasts but a few weeks from the time of the onset, but in most instances the symptoms are manifest during the entire warm season.

The lid type usually has its onset a little later than the limbic form, and its symptoms continue several weeks beyond the limbic group of cases. The pathology of the lid type, however, may continue to be manifest throughout the winter months. This, however, occurs only in the long-standing cases of the lid form, where folliculosis has progressed to such an extent as to form new fibrous tissue in the subconjunctiva, penetrating into the tarsal cartilage.

I wish to emphasize that vernal conjunctivitis never has its onset in any other season than the spring.

PATHOLOGY

Pathological specimens of the lid type reveal nothing more than inflammatory tissue. In addition to round cell infiltration and the formation of new fibrous tissue, there is noted the pathology peculiar to the lid itself, namely the formation of new mucous glands, and the presence of eosinophilis in the tissues and in the blood-vessels. This pathology corresponds with that seen in other tissues that are subject to allergic disturbances. The presence of a large number of new mucous glands explains the characteristic chewing-gum mucus which is found in the advanced type of the lid form.

The limbic type has a very scant mucous secretion, comparable with that of any subacute inflammation of the bulbar conjunctiva. The chewing-gum mucus of the lid type is never seen in any other ocular disease. It is composed of mucus, epithelial cells, lymphocytes, and very frequently eosinophils. The pathology of the limbic type is comparable with urticaria of the skin, while the pathology of the lid type compares with eczema.

ETIOLOGY

There have been a number of theories advanced to explain the cause of this manifestation. One concerns itself with endocrine disturbance, another with the disturbed vagotonic state associated with deficiency of adrenalin, and another with allergy.

The author no longer theorizes, but offers evidence by actual experiment on a group of 125 cases, that there is but one cause of vernal conjunctivitis, namely that it is a true allergy to the pollens of trees, grasses, and sometimes weeds.

As in other allergic diseases, there may develop a sensitivity to street dust, to animal extracts, and to foods, but these latter findings are secondary manifestations and not primary.

The author, in association with Dr. Jerome Miller, has reproduced the clinical symptoms of vernal conjunctivitis out of season in patients who have been found to be sensitive by the intra-dermal test during a seasonal attack. Control patients did not show evidence of sensitivity. Out of forty-one patients on whom intra-dermal tests were performed, thirty-seven showed positive reactions. Of a group of eighty-three patients, the conjunctival test was positive in forty-three instances.

Seasonal occurrences of the disease coincident with the pollen season of trees and grasses, the high incidence of family history of atopy, the presence of eosinophils in the smear from the eye, and the high eosinophilia in a majority of the cases of vernal conjunctivitis, point in the direction of an allergy as the basis for the cause of this disease.

TREATMENT

Granted that the pollens come in contact with the conjunctiva of the eye, the treatment, therefore, concerns itself with the removal of those causative agents. This may be accomplished with flushing of the eyes at frequent intervals, preferably seven times a day, with a solution of cold boric acid. An eye-cup will be necessary for the purpose of flushing. A cold solution is used because of its beneficial effect in reducing the itching. Patients are usually instructed to keep the boric acid solution in the icebox where the temperature varies from 50

to 60 degrees. Inasmuch as the itching is most severe at sundown, flushing of the eyes is emphasized at this time.

Patients complain severely of the itching causing them to rub the eyes repeatedly until they are able to remove from the eyes a chewing-gum mucus.

After experimenting with many preparations used in the eye for the purpose of liquifying this mucus, I discovered that sodium carbonate (monohydrated) in a one per cent solution will sufficiently break down the mucus so as to enable its easy removal from the eye. I accordingly recommend this preparation to be used: three drops four times daily after the flushing with boric acid solution. This preparation reduces to a large extent the itching caused by the presence of the mucus. It is very effective after it has been in use for several days.

It is necessary, however, to give the patient instant relief from symptoms. In order to accomplish this, I recommend the use of adrenalin 1/1000, three drops at frequent intervals, plus three drops of holocaine in one per cent solution.

Cold compresses on the eye will also assist in producing comfort. I recommend the use of tinted lenses for constant use; first, for the purpose of reducing the sensitivity of the eye caused by the inflammation, and secondly, to act as wind goggles, reducing the amount of pollens and dusts which may enter.

Many patients secure immediate relief upon entering air-cooled and air-filtered moving picture theatres. Patients are urged to keep their windows in the bedrooms closed at all times.

I have discontinued the use of radium in the lid type. Although the large follicles incident to the disease are reduced in size, radium does not remove the itching, hyperemia, and lacrimation because it does not remove the allergy. In the advanced lid types where granulomas develop, the mechanical pressure of the follicles against the cornea makes it necessary to perform a tarsectomy, including the involved conjunctiva. The lower lids are never so involved as the upper, and therefore, do not require the same surgical interference.

Desensitization between seasonal attacks has been practiced by my associate, Dr. Jerome Miller, and by Dr. Louis Tuft, who has acted as consultant in recent research work.

I am personally inclined to rely entirely upon local treatment, particularly in limbic cases where the disease is self-limiting in two to five years. In the lid type desensitization has some value, but I personally place more stress upon the local treatment. If the patients are made comfortable during the spring and summer months, they all desensitize themselves in due time.

The lid cases vary in duration from one to six seasons, the average case being four seasons. Of course there are instances where the disease may recur after many years, the oldest patient being fifty-nine, having had seasonal attacks since childhood. This is a rare instance, however. By far the greatest proportion of all cases recover under local treatment after an average of five seasonal attacks.

1321 Spruce Street

DISCUSSION BY DR. GEORGE MEYER, CAMDEN, N. J.

Fifteen years ago I had occasion to study the eye reactions to pollens in a number of cases of vernal conjunctivitis in the Allergy Clinic of the Jefferson Hospital in Philadelphia. Positive reactions were few, and our attempts to demonstrate the etiologic importance of pollens were disappointing. Many factors may have played a part in making it difficult to elicit positive reactions:

1. The conjunctiva may not be sensitive to an aqueous extract, but might be to whole pollen or pollen oils.

2. The local reaction in the eyes as manifested in vernal conjunctivitis may be a delayed one, such as is met with in contact dermatitis.

3. Bacterial allergy may play a part in some of these cases, but this question has not been adequately investigated.

4. The eye reaction may be the expression of a multiple sensitivity. Two or more factors may have to operate in seeming symbiotic collaboration to induce this clinical picture. For example, many patients are sensitive to face powders during a hay fever season when the pollen has seemingly sensitized the nose, whereas at other times of the year face powders cause no trouble. It may be that an analogous situation is present in vernal catarrah.

I am glad to know that Dr. Lehrfeld has satisfied himself that pollens are the causative agents. If he feels that this is true, would it not be wise to employ desensitizing injections as wel. as local treatments? Dr. Lehrfeld has done a great deal of work in this field, and I am sure we all feel grateful for his interesting pictures and profitable talk.

OBJECTIVES OF A COUNTY MEDICAL SOCIETY

AN ADDRESS TO THE MIDDLESEX COUNTY MEDICAL SOCIETY, OCT. 20, 1937

By William G. Herrman, M.D., Asbury Park, President, The Medical Society of New Jersey

It was a hot, sultry day in late September; the place was the William Penn Hotel in downtown Pittsburgh; the occasion was a convention of the American Roentgen Ray Society; the speaker was Dr. Sosman, of the Peter Ben Brigham Hospital in Boston, and his subject was "Hard-Hearted People". Most of the audience was asleep until Dr. Sosman started his scientific paper by quoting from the Bible, "And Pharaoh hardened his heart". This, he said, was the first case on record in antiquity of arterio sclerosis. He then went on to enumerate the three classes of people who had various forms of hardening of the heart, and he said, "I do not include hospital superintendents".

CO-OPERATION WITH HOSPITAL ADMINISTRATORS

This year one of the principal objectives of our State Medical Society is the improvement in relationship between the administrative side of hospitals and the medical and surgical staffs. Many times the disagreements between the hospital administration and medical staffs are due to misunderstanding, and not to constrictive pericarditis or hardening of the heart, for either one side or the other. It is essential that we make some effort to clear up such misunderstanding. This can only be accomplished through closer coöperation and interchange of ideas, and this means increased physician representation on boards of management.

Members of medical staffs are often very ignorant of administrative problems and of financial worries carried by the trustees. I believe in every hospital there should be a joint conference committee, and this should meet at regular intervals, so that members of the staff and members of the board of trustees may become better acquainted. They should get together even though there is no immediate problem to solve. Physicians and surgeons can be more economical in their use of hospital equipment and materials. They can be more careful and selective of the patients they send to the hospital for free services. They can be more energetic in soliciting support, both moral and financial, of their patients for the institutions with which they are connected.

HOSPITAL INSURANCE

I believe that we as a group can give hospitals very material help financially by boosting *hospital insurance*. There are many phases of hospital insurance policies with which we do not agree. Our best chance of correcting such policies and seeing that ones are issued which we can heartedly support is by getting back of the principle and encouraging our patients to take out either group or individual hospital insurance policies. The cost of medical care is constantly increasing. It cannot come down, but it must go up. The only way of softening the blow that a hospital illness entails on the individual is on the insurance principle.

CORPORATE MEDICINE

Many hospitals in their struggle to make both ends meet have adopted questionable practices which include the practice of *corporate medicine*. This is especially evident in the care of compensation cases in hospital clinics and wards. I have asked our compensation committee, together with the legislative committee, to prepare either a new compensation act, or amendments to the present act, in order to eliminate some of these abuses. Perhaps if we make more effort to be properly represented on hospital boards, and if we make more effort to understand hospital administration problems, and if we assure our institutions we are sympathetic and anxious to help them solve their own problems, we may have some of the things which we criticize corrected without resorting to legislation.

CONCRETE OBJECTIVES

We hear so much talk of organized medicine. Organized medicine should not consist merely of the organization of a lot of committees, of a lot of titles, of occasional meetings, and of much writing. Organized medicine should mean the combined effort of the individual practitioner of medicine to improve public health, to improve the practice of medicine, and to safeguard and improve the economic status of the practitioner of medicine. We should, therefore, each year have some very definite and concrete objective for which we can use our organization.

In the past, organized medicine of New Jersey has some concrete accomplishments; for instance, we were successful in the passage of the *doctor's lien bill*. This enables all physicians who take care of liability cases to secure

payment of at least part of their fee. Many States do not have this. In such States the staffs of hospitals who take in automobile accident cases are dependent entirely upon the good will of their patients for remuneration following the care of cases who are literally dumped on their doorstep. It is strange how short-lived the gratitude of some people is for the care and attention in saving their lives.

During the past few years coöperation with the relief administration in this State meant that the doctors of the State received approximately one million dollars for the care of those that they would have taken care of anyway for nothing, had not organized medicine been active in arranging a plan of the E. R. A. with which you are all familiar.

During the past year, and this one too, organized medicine has been actively coöperating with the State and Federal government in the rendering of service and the spending of money for the care of those who come under the medical aspects of the *Social Security Act.* Under this coöperation, as you know, men in the private practice of medicine are giving their time and assistance in baby keep-well stations, in the care of crippled kiddies, in the improvement of maternal welfare, and in the manning of venereal disease clinics. If it were not for our organization, full-time medical men on salary would be doing this work, and a good-sized wedge for socialized medicine would have been driven deep into the State of New Jersey.

I believe that there are very definite concrete ends to be obtained which will be both for the public benefit and our own which we can strive for this year. I have already spoken on the subject of improving hospital relations both from the standpoint of us giving assistance to the institutions, and from the standpoint of the hospitals correcting the abuses whereby we are competing with ourselves, and also of giving us better representation in the institution in which we spend so large a part of our lives.

There are other things for which we should strive in the very near future. We are lamentably weak as a State to care for those stricken with cancer and allied diseases. We have no institutions for taking care of the indigent or those who are living on a minimum wage when they have passed beyond the hope of cure, and need good nursing care and relief from pain. Many of our counties send such people out of the State to charitable or church institutions in New York or Pennsylvania. There should be facilities within our own borders. We are a wealthy State, with considerable public and private money available. I have recently been assured that if we can present a plan that is reasonable, the State will look upon it with favor. If we accomplish nothing else this year, that will be something of which to boast. Out of 171 hospitals canvassed by our Cancer Control Committee last year, only eight in the entire State were found with sufficient facilities to give all types of cancer cases modern treatment,—this to include, of course, surgery, and deep x-ray therapy, and radium where needed. I believe that our organization in coöperation with lay organizations can develop a plan by which adequate care can be rendered to the people of New Jersey no matter where they reside, and that the medical profession can be paid according to the economic status of the patient. I am working on such a plan now and hope to be able to give you the details of this later on.

MEDICAL PRACTICE ACT

I also believe that our present act governing the practice of medicine can be very greatly improved. I have asked our Legislative Committee to give this matter consideration. The correction of some of the abuses and loopholes in our present compensation act are interrelated to our practice act. We should have a medical practice act that will protect honest insurance companies and employers against unethical practitioners where such exist. Insurance companies have asked that there be some way by which the Board of Medical Examiners may be able to discipline those who abuse their privileges or at least may take cognizance and investigate reasonable complaints by insurance carriers and employers. I believe that, if we should show some desire of removing the mote from our own eye, that those on the other side of the fence will be more than glad to help us correct those phases of the present compensation act to which we object.

PUBLIC RELATIONS

You have in your own county society a very important member of the State Society this year—I refer to Dr. Kler, Chairman of the *Public Relations Committee.* This is a comparatively new committee. It is really the voice of the medical profession speaking to the public at large. We must place our cause before the public, and we must win their favor,—without that we can accomplish nothing. Dr. Kler's work is a bit of advertising, a lot of education, and some propaganda. It must be carefully done, and cleverly done. The patent medicine vendor and the quack are before the public at all times, through the radio and newspapers. Our only way of counteracting the impression of these people upon the public is

through our giving to the public the proper answer to many of the questions that they ask, and the proper information on matters of health and medical care. I am firmly convinced that, if we can lay the facts as we understand them before the public, we have little to fear from compulsory health insurance or state medicine.

I have never been licensed to practice medicine in Middlesex County, and yet I look upon it as one of my homes. I went to college in your county for four years, and was a member of the staff of one of your institutions for six years. Many of my closest friends, both lay and professional, reside in this county. It is always a pleasure to come back to Middlesex, and to appear on the program of the Middlesex County Medical Society. As you know, the work of the President in the last few years has vastly increased, and it is no longer feasible for one man to visit all twenty-one counties during his year in office. For this reason, we have divided up the county meetings among the various executive officers. I am appearing before only six county societies this year. Of these six, Middlesex was personally chosen by me. Allow me to thank you for inviting me to be present at this meeting; and always believe that your organization is very close to my heart.

MATERNAL WELFARE OBJECTIVES

MATERNAL WELFARE ARTICLE NUMBER TWENTY-ONE

By Arthur W. Bingham, M.D., East Orange, N. J.
Chairman, Committee on Maternal Welfare of The Medical Society of New Jersey

A National Broadcast over WABC, on June 2, 1937

Maternal Welfare is a responsibility of the physician, the medical school, the nurse, the hospital, the community and the patient.

THE PHYSICIAN

The physician should have received sufficient education to enable him to conduct an average maternity case from start to finish. If he does not feel competent, he should take a postgraduate course and become more proficient. He should continue his education by attending medical meetings and reading obstetrical journals.

Only two suggestions are made to the physician:

1. More care should be used in conducting the normal case in order to prevent complications and to keep the normal case normal. This applies to prenatal, delivery, and postnatal care.
2. Earlier and more frequent consultations should be had in abnormal cases.

THE MEDICAL SCHOOL

The medical school has a responsibility. It should study its curriculum and make sure it is giving sufficient instruction in practical obstetrics.

THE NURSE

The nurse has a responsibility. She should urge the patient to see her physician early in pregnancy, and encourage her to carry out instructions.

THE HOSPITAL

The hospital has a responsibility. No hospital should accept maternity cases without having the proper equipment, except in an emergency.

The hospital unit should include the following points:

1. Isolated obstetrical department.
   a. Separate building (preferable); or
   b. Separate floor or wing.
2. Supervision of department by a competent obstetrical staff, with provision for an ample courtesy staff.
3. Standard routine procedures to be adopted by obstetrical staff and followed by all physicians attending cases.
4. Rules requiring consultation in abnormal cases.
5. Provision should be made for isolation of infected cases.
6. Adequate records should be kept in order

to study cases and tabulate results in an annual report.

7. Obstetrical staff conferences held regularly and open to all physicians interested. Sometimes this is made obligatory for courtesy staff as well as regular staff members.

8. Prenatal clinics as part of a comprehensive community system of prenatal care.

THE COMMUNITY

The community has a responsibility. Every community should have an adequate obstetrical hospital unit. It is largely a matter of finances. If no such provision for hospitalization is at hand, steps should be taken to procure funds to establish such a unit.

Every community should also have its maternity center to give adequate prenatal care to those patients who cannot afford a physician, as well as to assist the physicians in giving prenatal care to their patients. The maternity center should also include nursing delivery service and follow-up nursing care in home deliveries. This can be organized at a moderate expense and will pay large dividends in saving lives. A maternity center should consist of a visiting nursing association working in conjunction with hospital or other prenatal clinics. The Maternity Center of New York or the Maternity Center of the Oranges, N. J., and others will be glad to help organize this work. Any community which has an adequate community obstetrical hospital and a community maternity center has taken an important step in advancing maternal welfare.

THE PATIENT

The patient herself has a responsibility. Before pregnancy occurs, she should have a physical examination to see if she is physically sound. If abnormalities are found, these should be corrected if possible. A Wassermann test should be made.

At one time, pregnancy was considered a physiological process which should be followed by a normal completion; and there was thought to be no necessity for the pregnant woman to place herself in the care of the obstetrician until a short time before her expected confinement. These views have changed, and patients are becoming educated to the fact that, while normal pregnancy is physiological, the possibility of pathological conditions occurring is so great that the pregnant patient can safeguard her pregnancy only by placing herself in the hands of her physician as early as possible.

When pregnancy occurs, she should place herself under the care of her physician, or a prenatal clinic, as early as possible. She should select a physician who is sufficiently interested and sufficiently well trained to handle the case properly.

She should avoid an abortion. Nearly one-fourth of all the maternal deaths in New Jersey last year were due to abortions, and the ratio is about the same throughout the country. Too much exercise and lifting in the early months, as well as long automobile rides, are frequent causes of abortions. Many are intentional and cause complications which are frequently responsible for sterility and general poor health.

The patient should walk in the sunshine and thus improve her metabolism; and, also, eat the right kind and the right amount of food so as not to gain weight too rapidly. Walking will help to keep down the weight, as well as aid the baby in settling into the pelvis. Overweight due to excess fat and a disturbed metabolism is a frequent cause of toxemia, kidney disease, and difficult labor with its resulting complications. She can preserve the teeth by careful cleaning after meals, followed by a mouth wash; and by keeping in good condition. Calcium may be necessary in some cases. She can help to prevent anemia by appropriate diet, plenty of fresh air, and sunshine. Iron may be prescribed by the physician. The patient should care for the breasts and nipples to prevent trouble during the nursing period.

The nausea may be lessened by eating frequently of starchy food, and not exercising too much during the first three months. Muscular cramps can be relieved by the proper use of calcium and viosterol. Tobacco and alcohol should be used very sparingly, if at all.

The patient should try to keep herself in the best possible condition, the same as an athlete preparing for a contest. She should see her physician frequently for a general check-up including urinalysis, blood pressure, etc.

The danger signals to be reported to the physician are: Severe vomiting, marked constipation, headaches, dizziness, abdominal pain, scanty urination, any discharge of blood or any other excessive discharge, swelling of hands, feet, eyes, or face, and excessive gain in weight.

She should consult her physician or nurse as to what to do and what to provde if going to a hospital and what to have ready if intending to stay at home.

She should not neglect to return to her physician for a follow-up examination six weeks after the birth of the baby.

Too often the patient receives her education by reading sensational articles and listening to her friends tell of the many serious complications which rarely occur. She should understand that, if she will follow instructions, complications will seldom develop.

Many maternal deaths are caused by the failure of the patient to take advantage of the facilities which are at hand for safeguarding her in the period of pregnancy, labor, and convalescence. Coöperation is necessary.

Under the direction of the American Committee on Maternal Welfare, this work is being carried on all over the country. Most of the State Medical Societies, coöperating with the State Departments of Health, are now taking an active part.

COMMITTEE PROGRAM

The Committee on Maternal Welfare of The Medical Society of New Jersey was appointed in 1931. During the past year, it has been cooperating with the State Department of Health. During the six years, the uncorrected maternal mortality rate in the State has dropped from 5.9 to 3.7 per thousand live births. The following is the New Jersey program:

1. Adequate provision should be available for prenatal care:
   a. By physicians in their offices;
   b. In prenatal centers to be established where needed.
2. Hospitals should have isolated maternity departments; either separate building, wing, or floor.
3. Hospitals should allow general practitioners to attend their own patients, subject to supervision by an obstetrical staff, and with rules for consultation in abnormal conditions.
4. Regular conferences of maternal welfare groups should be held with all physicians interested in obstetrics for discussion of causes of complications, how to prevent them, and how to treat them; as well as reasons for maternal deaths.
5. Every maternal death is investigated, not for criticism, but to check diagnosis and cause of death, and to prevent another.
6. Sixteen field physicians were appointed to work in different districts throughout the State, and this year one is appointed for each county. The field physicians are the contact physicians between the Committee on Maternal Welfare of the State Medical Society, the physicians all over the State, and the State Board of Health. They try to stimulate the doctors to adopt and carry out approved and accepted standards of prenatal, delivery, and postnatal care. They inspect the various hospitals taking maternity cases and suggest the adoption of the rules recommended by the State Committee. They get an obstetrical report from each hospital each year. They also check on the maternal deaths in each district.
7. Free nursing delivery service is provided for the low-wage group of patients. In these cases a physician may call any registered trained nurse. Free consultations are available for the low-wage group. A physician or midwife needing consultation on one of this group may call any competent physician to assist.
8. Lecture courses have been given, and will be continued as lectures or conferences with groups of physicians interested in obstetrics.
9. Refresher courses are given for those who wish to observe some of the more modern methods in obstetrics.
10. Literature on prenatal care, delivery, and postnatal care, as well as instructions to expectant mothers, is being widely distributed.
11. A maternal welfare article is printed each month in the Journal of The Medical Society of New Jersey.

OUR GOAL

Adequate supervision and care for every expectant mother in New Jersey.

SCIENTIFIC EXHIBITS

THE SCIENTIFIC EXHIBITS OF THE 1937 ANNUAL MEETING

ARTICLE NUMBER FOUR

EXHIBIT NUMBER THIRTEEN
TUBERCULOSIS IN HIGH SCHOOL STUDENTS

By Abraham E. Jaffin, M.D., F.A.C.P., Jersey City, N. J.



Exhibit No. 13.—Tuberculosis in High School Students of Jersey City

The recent exhibit entitled *The Danger of the Unrecognized Case of Tuberculosis in High School Students* was undertaken for several reasons:

1. Because of the well-known fact that the curve of morbidity and mortality from tuberculosis begins its rise in the neglected teen age.
2. A considerable number of cases of adult pulmonary tuberculosis were being encountered in the high school age.
3. Most of these cases were more or less advanced by the time they applied for treatment.
4. All cases could be recognized if tuberculin surveys were made, and the positive reactors x-rayed periodically.

These facts convinced us that the next step in the further prevention of tuberculosis was the universal tuberculin testing of all children or adolescents, especially those in the teen age. We were further convinced that the high school groups offered the most fruitful field for a demonstration of this plan.

All physicians, as well as the public, must be educated to the great value of the Mantoux test. They must be shown that by means of it, properly conducted with a standard preparation of tuberculin, every child previously infected with tuberculosis can be recognized as a contact.

The next step is the x-raying of all the contacts and further search in the child's household or environment for a source of infection and other contacts.

Charts and papers were prepared by pupils in the Jersey City High Schools, illustrating these facts, as follows:

1. Posters featuring appropriate quotations from the literature on the subject, emphasizing the steep rise in the incidence of tuberculosis in

high school students, and charts giving figures from various surveys. These included students, teachers and other personnel.

2. Facing this part of the exhibit was another indicating the rôle of the family physician in extending the methods of early diagnosis and elimination of tuberculosis to his own field of practice. This illustrated the technic of the Mantoux test, and the value of the same as a lead to other cases in the family or the child's environment. Particular emphasis was placed upon the fact that the general practitioner, because of the trust placed in him by his patients, should be trained in the newest and best methods of diagnosis for the early discovery and elimination of tuberculosis.

3. Between these two panels, there was a third, exhibiting a large series of actual cases recently encountered in our high schools. These varied from the earliest minimal exudates, accidentally discovered, to very far advanced forms with marked clinical symptoms and signs. The results of rest and early collapse were also demonstrated.

The main purpose of the exhibit was to make the profession, especially the general practitioner, school physician, and all interested in public health measures more familiar with the value of these modern methods of earlier diagnosis and prevention of tuberculosis.

The principal weapons recommended in this extension of the campaign against tuberculosis were universal Mantoux testing of all children and adolescents, supplemented by rapid mass x-ray of all positive reactors. The x-ray procedure was illustrated by photographs of the method; and also by a sample roll of one hundred paper roentgenograms. These films were found very satisfactory for the detection of childhood and adult type of disease, particularly,—as well as for such abnormalities as pleurisy, cardiac disease, etc.

This method of roentgen study was not intended to supplant the film, but to discover evidence of any kind that needed further clinical observation.

It was further recommended that these surveys be repeated annually in the following manner:

1. All negative reactors retested annually.
2. All positive reactors and cases of childhood type tuberculosis be re-x-rayed annually or more often, if indicated.
3. All cases with evidence of adult or reinfection type of tuberculosis be referred at once to their family physician or clinic, if necessary, for further supervision and care.

EXHIBIT NUMBER FORTY-FIVE

TUBERCULOSIS CASE FINDING AMONG NURSES

By Berthold S. Pollak, M.D., and Samuel Cohen, M.D., Jersey City, N. J.

In recent years, there has been an increasing interest in the problem of tuberculosis among nurses. At the Jersey City Medical Center we have been making a determined and systematic effort in the early recognition and control of the disease among these young women. The present project was an outgrowth of a health program for nurses which was started at the institution in 1926 by Dr. George O'Hanlon, Medical Director.

The Medical Center is a general hospital with an average bed capacity of 1,000. The Tuberculosis Service has seventy beds; and during the year 1936 it received 412 out of more than 19,000 total hospital admissions. The student nurses have a three-year period of training. Most of them receive their tuberculosis ward training during the second year, and spend approximately two weeks on the service.

Since March, 1934, all nurses entering the training school have been tuberculin tested. The negative reactors are re-tested annually. Routine x-raying of the chests of the nurses was inaugurated in December, 1934. These films have been repeated every four months, and more often if indicated.

We have tabulated the results of the two-year x-ray survey (from December, 1934, to December 1, 1936) among the nurses as shown in table one.

The diagnosis in all of these cases except one was made before symptoms manifested themselves to such a degree as to make the nurses seek an examination. It was only later, after close questioning, that some admitted mild symptoms to which little significance was attached. Abnormal physical signs were absent in the great majority of cases.

In these early lesions, the question as to whether they are active or not, often arises. The best guide is the comparison of frequent

TABLE I.

I. Total number of nurses (graduates, students and affiliates examined by chest x-ray during this interval) 678

II. Total number of new diagnosed cases of re-infection type of pulmonary tuberculosis during this interval:
- A. Among applicants for nursing on admission 4
- B. Affiliate student nurses 2
- C. Students in Jersey City Medical Center 6
  (Out of 271 student nurses examined, 6 have developed tuberculosis during period of training, or 2.2 per cent.)
- D. Graduate nurses:
  - J. C. M. C. graduates 3
  - Graduates of other schools 4

  19, or 2.8 per cent of the individuals examined

III. Type of re-infection lesion:
- A. Minimal—14 parenchymal
  1 pleurisy with effusion
  15, or 79 per cent of total.
- B. Moderately advanced—4, or 21 per cent of the toal.

No roentgen evidence of recent primary infection was encountered in any of the negative reactors that later became positive reactors.

serial x-rays of the chest. We have found the determination of the sedimentation rate to be of value at times as confirmatory evidence; but this test in itself cannot be considered as an infallible diagnostic or prognostic criterion.

To best visualize the efficacy of our present case-finding program, we undertook a tabulation of the *diagnosed cases* of pulmonary tuberculosis among the nurses at the hospital during the five-year period between January, 1930, and December 1, 1934, inclusive, prior to the use of frequent routine radioscopic examinations; and compared these findings with those of our present survey.

The striking facts to be reëmphasized are: (1) We are apparently detecting more cases of pulmonary tuberculosis with our present methods than heretofore; (2) in our present survey, 79 per cent were diagnosed in the early or minimal stage; 21 per cent as moderately advanced; and none in the far advanced group. Of these, only three thus far, or 15.7 per cent, have been treated by collapse methods (artificial pneumothorax). This is in marked contrast to the finding of the antecedent five-year interval, when 39 per cent had minimal lesions; 61 per cent moderately to far advanced lesions; and in eleven, or 48 per cent of cases, collapse therapy had been undertaken (including artificial pneumothorax, phrenicectomy, thoracoplasty).

We are continuing with our x-ray survey (six additional cases of pulmonary tuberculosis have been discovered between December 1, 1936, and May 1, 1937), because we are firmly convinced that frequent periodic x-ray examinations of the lungs mean the recognition of incipient tutberculosis, usually in the asymptomatic stage, which responds favorably with prompt, simple, adequate bed-rest treatment as a rule. This is the keynote of our humble effort.

We are greatly indebted for the splendid coöperation given to this project by Dr. George O'Hanlon, Miss J. M. Murdoch, Director of Nurses' Training School; Dr. L. F. Fuld, Health Director, and the Misses E. Cohoon and M. Church, who helped in assembling data. The tuberculin testing has been carried on by Dr. A. E. Jaffin, Chief of Tuberculosis Clinics.

TABLE II.

TABLE TO SHOW VALUE OF FREQUENT ROUTINE X-RAYS IN DETECTING PULMONARY TUBERCULOSIS

Diagnosed Cases of Pulmonary Tuberculosis	Total Number of Cases	*Classification of Cases*			*Total Number of Collapse Therapy Cases*		
		Minimal	Moderately Advanced	Far Advanced	Artificial Pneumothorax	Phrenicectomy	Thoracoplasty
From Jan., 1930, to Dec. 1, 1934—five-year period (prior to x-ray)	23	9, or 39%	9, or 39%	5, or 22%	11	3, See note 1	1, See note 1
From Dec. 1, 1934, to Dec., 1936—(two-year period of x-ray survey)	19	15, or 79%	4, or 21%	0	3, See note 2	0	0

Note 1.—In two cases, phrenicectomy supplemented artificial pneumothorax; in one case, it was performed on a discontinued pneumothorax case; a thoracoplasty was done on a discontinued pneumothorax case.

Note 2.—In two cases, artificial pneumothorax was induced at the Medical Center; a third case was started on this therapy elsewhere after leaving the Center; in a fourth case (affiliate student nurse), artificial pneumothorax was recommended to her hospital authorities. The remainder of the clinically active cases of tuberculosis have been treated by bed rest.

STATE SOCIETY ACTIVITIES

CONFERENCE OF STATE SECRETARIES AND EDITORS

The nineteenth annual Conference of the Secretaries and Editors of the several State Medical Societies was held on Friday and Saturday, November 19 and 20, 1937, in the building of the American Medical Association, 535 North Dearborn Street, Chicago, Illinois, and at the expense of the Association, including the travel costs of the participants. Over 150 delegates were present, including three from New Jersey—Alfred Stahl, Secretary; LeRoy A. Wilkes, Executive Officer, and Frank Overton, Editor.

The conference was what its name implies—an opportunity for the State officers to give and take information regarding their own local problems, and to obtain the information and inspiration which the extensive facilities of the A. M. A. can supply. Early in the Fall, Dr. Olin West, Secretary of the A. M. A., had invited each Secretary and Editor to send a list of subjects which he would like to hear discussed; and about twenty topics were selected and listed in the program. Dr. Walter F. Donaldson, Secretary of the Medical Society of Pennsylvania, was chosen presiding officer; and the remarks of the speakers were recorded by a stenotypist. The items of advice and information were well worthy of record, for they expressed the opinion and practice of the field workers of all parts of the nation.

The conference was opened by Dr. Arthur W. Booth, of Elmira, New York, Chairman of the A. M. A. Board of Trustees, who suggested that, during the present time of medical unrest and fear, physicians should heed the words of P. T. Barnum to "Hold your horses", —referring to the advance guard which warned the farmers of the approach of the circus parade with its wild animals and its noisy bands.

FULL-TIME SECRETARIES

Dr. J. H. Upham, President of the American Medical Association, in a brief address, referred to the development of the methods of private practice so that the progressive doctor now employs an office clerk to attend to the business details of his practice. Likewise a State Medical Society needs a full-time Secretary to attend to the routine items of its business, and insure prompt service to the members and the community.

COLLEGE STUDENT HEALTH

Student health services in colleges was the subject of a paper by J. D. Laux of the A. M. A. Staff, who pointed out the great variations in the objectives and methods of the institutions, many of them emphasizing instruction in public health, and few providing efficient medical advice to students who were actually sick.

GRADUATE COURSES

Typical methods of post-graduate instruction in four States were discussed by their representatives.

Pennsylvania—Dr. Walter F. Donaldson described the method adopted in Allegheny County (Pittsburgh), with 1300 members. Instruction is given to small classes of from six to twenty doctors, each of whom pay a fee of ten dollars per course.

The Philadelphia County Medical Society gives a course once a week which is free to all doctors.

For the rural counties the State Society provides the speakers and the county societies arrange the details, charging ten dollars to each physician registering in the course.

In 1936 the State Department of Health sponsored a course of instruction in maternal and child health without the coöperation of the State Medical Society. The courses were not particularly popular.

Connecticut—Dr. Creighton Barker, of New Haven, described the annual Clinical Congress that is held annually under the auspices of the Connecticut State Medical Society. The instruction is given over a period of five days in New Haven. The morning and evening of each day is given over to lectures to the whole assembly, and the afternoons to demonstrations to small groups. During the first years, the speakers chose the subjects which they thought the doctors needed; and one gave a demonstration of the auscultation of the skull. After that, the promoters adopted the subjects which were chosen by the physicians themselves.

The Congress has been a success, 1700 doctors attending in 1937.

North Carolina—Dr. T. W. M. Long, of Roanoke Rapids, North Carolina, in his introduction, said that his State was the first one to establish medical examinations as the basis for licensing practitioners of medicine. He described the pediatric courses which have been conducted throughout the State for over ten years, and which have reached over 2000 doctors, especially those in rural sections. The plan of each course is that a group of at least twelve doctors, each paying a fee of $30, shall provide cases for demonstration and treatment. The courses have been eminently practical and have been eagerly accepted by the local doctors. These courses were in operation long before Federal aid was suggested.

Texas—Dr. Holman Taylor described a system in Texas in which a course in maternal welfare and child health is arranged by each councilor district, the expenses being met from Federal funds.

EXHIBITS

Dr. Eben J. Carey, of Milwaukee, described the popular medical exhibit which was conducted in the City of Milwaukee by the Medical Society of the State of Wisconsin at its annual meeting, September 14-17, 1937. (A description of the exhibit was printed in this Journal of October, p. 632, being abstracted from the Wisconsin Journal of September, p. 761—Editor's note).

The exhibits were contained in a large hall, with wide aisles which were crowded through the whole of every day and evening, a total of 105,000 persons visiting it during the week. The exhibits were explained and demonstrated by eighteen medical students.

The expense of the exhibit was above $3500, but the result justified the expense, for the popular opinion which it aroused was a major factor in influencing legislators to defeat some bills that were threats to public health.

ADEQUATE MEDICAL CARE

Dr. Irvin Abell, of Louisville, Kentucky, President-Elect of the A. M. A., discussed the question of what constitutes "Adequate" medical care. The idea taught in the medical college and research hospital is that all cases should be examined in all possible ways; but less than ten per cent of even those cases require this exhaustive study.

Medical care is adequate if it results in restoring the patient to comfort and health.

A NATIONAL MEDICAL POLICY

Dr. Olin West described the events which have grown out of the action of the House of Delegates on June 7, 1937, in rejecting the proposals of the delegation from New York State. Dr. West said that the proposals were similar to those of an advisory committee of the American Foundation Studies in Government, whose report was issued on April 1, 1937. (See this Journal, April, 1937, p. 292.) After the A. M. A. had rejected the New York State resolution, some of the proponents of the Foundation's report formed a self-constituted committee often called "Committee of 430", named after the number of physicians who signed an agreement to promote the adoption of proposals somewhat like those of the New York Delegation. One of the major objections to the proposals is that they create the impression that physicians are split into two parties, one which is promoting socialized medicine, and the other the personal relations of physicians and patient.

The Trustees of the A. M. A., meeting on November 19, 1937, adopted the statement which is printed on page 745 of this Journal.

MEDICAL TREATMENT OF GOVERNMENT EMPLOYEES

Dr. Olin West described the Group Health Association, Inc., that has been formed in the District of Columbia for treating the employees of the Federal Government, who are estimated to number 115,000, and also the members of their families. (See Jour. A. M. A., Oct. 2, 1937, pages 39B-46B.) If the scheme is adopted, private practice will be seriously affected.

The proposal is that an individual who is insured shall pay $2.50 monthly, or $3.50 if he wishes to include the members of his family; and for it he and his dependents shall be entitled to free treatment and a period of hospitalization. A government grant of $20,000 has been made to the corporation, but on what authority no one seemed to know.

FIELD PHYSICIANS OF NEW JERSEY

Dr. LeRoy A. Wilkes, Executive Officer of The Medical Society of New Jersey, described "New Jersey's Coöperative Program for Maternal and Child Health". He emphasized the fact that for years the State Society had maintained active committees on Maternal and Child Health which were doing efficient work in cooperation with the State Department of Health. The Federal funds enabled these organizations to establish a system of "Field Physicians", composed of members of the county societies

and appointed as councilors and advisers of physicians who practice obstetrics and pediatrics.

A discussion of the activities in Illinois, Nebraska, Pennsylvania, and South Dakota, under the Social Security Act seemed to indicate that their success and popularity was in proportion to the efficiency of the machinery that was already in operation in those States when the new system was introduced.

PNEUMONIA CONTROL

Pneumonia prevention and control in New York State was described by Dr. Peter Irving, Secretary of the Medical Society of the State of New York. The State is fortunate in having an appropriation of $400,000 by the Legislature, for the production and administration of serum for the use of any person who has pneumonia. Since the serum for an average case costs $50, the appropriation is a great aid in providing it for all cases of the disease.

The State of New York is also giving service along the other essential lines, such as the prompt typing of sputum for early diagnosis.

LEGAL PROCEDURES BY COUNTY SOCIETIES

W. C. Woodward, Director of Bureau of Legal Medicine and Legislation of the A. M. A., discussed several legal problems, and particularly called attention to the necessity that each county society should follow the provisions of its constitution and by-laws, especially in questions of discipline, when the rules of law, and not of medicine, must prevail. Membership in a county society has a legal value of which a doctor cannot be deprived without the observance of every legal requirement.

EDITORIAL SESSION

The Friday evening session was a supper meeting held in the Palmer House, when the presiding officer was Dr. E. M. Shanklin, Editor of the Journal of the Indiana State Medical Association.

The only formal paper was that by Dr. J. H. Dempster, Editor of the Journal of the Michigan State Medical Society, whose subject was "Better Papers for State Medical Journals". Dr. Dempster described the standards of good medical writing. This he was well qualified to discuss since he instructs medical students in the art of clear writing, and has issued a book on the subject. He told of the standards for the acceptance of articles in the Michigan Journal, and distributed printed instructions to which authors must conform in order to have their articles published in the Michigan State Journal of Medicine.

In the discussion the fact was brought out that writing, like oratory, or accounting, or musical performance, is a special gift which some excellent doctors do not have. If the editor has the time, he will assist these writers by editing their productions and making them readable. But only a few medical editors are on full-time salary and so they are compelled to require an article to be in excellent shape before it is accepted.

The same principles apply to the *illustrations*. It is the custom of nearly all medical journals that the authors of papers shall pay the cost of making the plates for illustrations. Here the full-time editor can be of great assistance to the authors, especially if he is a photographer.

Dr. George H. Kress, Editor of California and Western Medicine, spoke of official reports that need revision and clarification, and said that this work often falls by necessity upon the editor. The editor cannot reject these as he can scientific papers.

Dr. C. Q. Smith, Editor of Northwest Medicine, and Dr. Holman Taylor, Editor of the Texas Journal, told of amusing complaints and threats arising from the rejection or editing of school-boy papers of authors, and the pride of other authors in their articles which had been completely rewritten by the editor.

There was considerable discussion of the costs of publication and attention was called to the wide variation in the published figures, owing to the different methods of bookkeeping. Some editors reported that they made new printing contracts every two years, and that the bids of some printers were two or three times as much as those of others.

It was developed that the extra large bills were often due to changes in the editor's copy, and that the wisest course is to patronize the same printer year after year so that he will learn the requirements of the journal, and will adapt himself to them, so that few corrections will need be made.

The standard method of charging is that the printer shall submit an itemized bill for each issue of the journal, based on current rates for paper and for typesetting, and other routine processes. Printers, like building contractors, expect to make money by doing work that involves extensive changes in the original copy. If the manuscript is perfect, the printer will have no excuse for making changes.

Dr. Frank Overton, Editor of The Journal of The Medical Society of New Jersey, pointed out the great desirability that the editors insert cross-references to the particular journal and

pages on which to find descriptions of the events to which references are made in the text. It is aggravating to read such expressions as "On another page", or "In a recent issue", or "In the A. M. A. Journal", and then be unable to locate the article. These references are of importance in confirming or amplifying an author's opinion or statement; and the editor should require the author to supply the exact sources of the references.

PRINCIPLES AND PROPOSALS OF THE COMMITTEE OF 430 PHYSICIANS

The Board of Trustees of the American Medical Association, meeting on November 19, 1937, authorized the publication of the following statement, which appeared in the Journal of the A. M. A. of November 27, page 1816:

The Board of Trustees of the American Medical Association has especially authorized the publication of the following statement:

Following the publication of the report of the American Foundation Studies in Government, a small group of physicians, assembled in New York, developed certain principles and proposals which have since been circulated by a self-appointed Committee of Physicians among the medical profession of the United States, with a view to obtaining signatures in their support. During a period of approximately six months, some 430 medical men have apparently permitted the use of their names. Early in November the self-appointed group of physicians released to the press for Sunday, November 7, a statement of principles and proposals to which the names of the 430 signers were affixed. The newspapers generally heralded this action as a revolt against the American Medical Association, in a great majority of the cases indicating that there was a revolt in behalf of "state medicine". The publication of this manifesto and the attached signatures has been heralded with glee by many of those who have been opposing the American Medical Association in behalf of coöperative practice, sickness insurance, and various fundamental changes in the nature of the practice of medicine. Within the last week another series of proposals has come from another self-appointed group requesting signatures of physicians. This series of proposals includes the suggestion for enabling legislation for sickness insurance.

The American Medical Association is an organization of physicians along strictly democratic lines. Representatives of county medical societies send delegates to state medical societies and these, in turn, send their delegates to the House of Delegates of the American Medical Association. It is possible for any physician, through his delegate, to obtain consideration of any proposal which he may wish to bring to the attention of the House of Delegates. At the Atlantic City session the delegates from New York State presented these principles and proposals, slightly modified, as an action of the House of Delegates of the New York State Medical Society. They were carried before a reference committee and, in several sessions of that reference committee, considerable numbers of physicians presented arguments for and against their adoption. The House of Delegates, however, after thorough consideration of the report of the reference committee, and with full cognizance of the method of development of these principles and proposals, and of the considerations which were involved in their passage by the House of Delegates of the New York State Medical Society, did not accept them. The House of Delegates did, however, point out the willingness of the medical profession to do its utmost today, as in the past, to provide adequate medical service for all those unable to pay either in whole or in part.

Why, then, any necessity for the circulation of petitions presenting proposals for fundamental changes in the nature of development, distribution and payment for medical service? Is there a well-designed plan to impress the executive and legislative branches of our government with the view that the American medical profession is disorganized, distrustful of its leaders, undemocratic in its action and opposed to the best interests of the people? Who may profit from such evidence of disorganization? Is there any evidence that the self-appointed Committee of Physicians and the 430 physicians who have affixed their names to these principles and proposals are any better able to represent the opinion of the American medical profession than the democratically chosen House of Delegates of the American Medical Association—one of the most truly representative bodies existing in any type of organized activity in this country today?

The House of Delegates has given its mandate to the Board of Trustees, to the officers and to the employees of the Association. That

mandate opposes the principles and proposals emanating from the Committee of Physicians, and equally the new proposals. If the House of Delegates sees fit to depart from the principles now established, it will be the duty of the Board of Trustees, the officers and the employees of the American Medical Association to promote such new principles as the House of Delegates may establish. Until, however, the regularly chosen representatives of the 106,000 physicians who constitute the membership of the American Medical Association (now the largest membership in its history) determine, after due consideration, that some fundamental change or revolution in the nature of development, distribution and payment for medical service in the United States is necessary, physicians will do well to abide by the principles which the House of Delegates has established. They will at the same time deprecate any attempts inclined to lead the executive and legislative branches of our government, as well as the people of the United States, into the belief that the American medical profession is disorganized.

Members of the medical profession, locally and in the various states, are ready and willing to consider, with other agencies, ways and means of meeting the problems of providing medical service and diagnostic laboratory facilities for all requiring such services and not able to meet the full cost thereof. The American Medical Association has reaffirmed its willingness on receipt of direct request to coöperate with any governmental or other qualified agency and to make available the information, observations and results of investigation, together with any facilities of the Association. Thus far, no call has come from any governmental or other qualified agency, for the cooperation of the American Medical Association in studying the need of all or of any groups of the people for medical service, to determine to what extent any considerable proportion of our public are actually suffering from lack of medical care. The offer still stands as evidence of the willingness of the American Medical Association to aid in finding a solution to any or all of the problems in the field of medical care that now prevail.

CONTACTS WITH CIVIC ORGANIZATIONS

The contacts which physicians have with organizations of a civic and social nature provide valuable opportunities for popular medical education. Dr. J. H. Kler, Chairman of the Sub-Committee on Public Relations, therefore is sending a blank card to every member of The Medical Society of New Jersey asking him to indicate his membership in the local organizations to which he belongs. The information sought is as follows:

Organizations to which you belong?
Are you an officer? Give office.
Are you a member of any committee?
State if chairman.

There are spaces for recording this data for eight organizations.

The letter accompanying this request is as follows:

The State Medical Society, as a group, has daily contacts with other organizations throughout the State. You can realize how extremely valuable it is to know the organizations to which each physician belongs, in order to facilitate our contacts in case we need to do so. This is especially true during these times of social unrest.

Because club membership is not stable, it is necessary to make this survey annually. Please fill in the enclosed questionnaire and return it in the self-addressed envelope prepared for your convenience. The organizations we are interested in are all the social, fraternal, church, educational, service clubs, and all other strictly non-medical societies.

Please return the "filled-in" form at your earliest convenience so that we may make the fullest use of it.

AMENDMENTS TO THE CONSTITUTION

Article twelve of the Constitution of The Medical Society of New Jersey specified the following method of adopting amendments:

"This Constitution may be amended by a two-thirds vote of the members present at any annual meeting, provided that the proposed amendments

"1—have been considered by the Committee on Revision of Constitution and By-Laws,

"2—and that they shall have been submitted in writing at a previous annual meeting,

"3—shall have been published in the Journal of this Society,

"4—and officially sent to each component society at least three (3) months before the annual meeting at which final action is to be taken."

In compliance with requirements one and two, the Committee on Constitution and By-Laws reported to the House of Delegates on the afternoon of Wednesday, April 28, 1937, that the committee had met and now submits two amendments as follows (see Transactions, 1937, page 49):

1. Amend the Constitution, Article IV, Section 3, entitled "Election of Delegates", so that in paragraph d entitled "Vacancies", the first sentence shall read as follows (new material is in italics):

"d. Vacancies. A vacancy shall exist in the delegation of any component society whenever one of its delegates ceases to be in good standing, *or fails to attend two consecutive meetings (annual or special) except in case of illness,* or resigns, or dies."

2. Amend the Constitution, Article IV, Section 5, entitled "Honorary Members", whose closing sentence now is "They shall have all the privileges of members, but shall not be members of the corporate body". The amendment adds the following sentence:

"This does not affect the rights of an officer, fellow, or active member of The Medical Society of New Jersey."

This publication of the amendments constitutes a compliance with the third condition of amending the Constitution.

On November 15, 1937, Secretary Alfred Stahl complied with the fourth requirement in amending the Constitution by mailing copies of the two amendments to the President and the Secretary of each County Medical Society.

FIELD PHYSICIANS

The system of Field Physicians is organized under the joint auspices of The Medical Society of New Jersey and the State Department of Health, and is part of the plan submitted to, and approved by, the Federal Children's Bureau in accordance with the provisions of the Federal Society Security Act of 1935. The object of the act is to provide better health care for mothers and children, especially in rural areas throughout the nation. For this purpose the Social Security Act of August 14, 1935, made available for distribution to the various States $3,800,000, of which New Jersey receives $68,000 each year.

The State Department of Health is the responsible agency for preparing, supervising, and carrying out plans to serve these general purposes. The Federal Children's Bureau is required by law to approve such plans as meet the conditions specified in the act. The Bureau of Maternal and Child Health of the New Jersey State Department of Health has submitted its plans, of which the Field Physician project is part, to the Maternal Welfare Committee, the Public Health Committee, and the Welfare Committee of The Medical Society of New Jersey for study and approval, before submitting these plans to the Children's Bureau. The Medical Society coöperates and participates in the carrying out of these plans through its Executive Officer, and its Maternal Welfare and Child Health Committees.

SCOPE OF DUTIES OF THE FIELD PHYSICIAN

The Field Physician, who is selected on account of his special interest and knowledge of maternal and child health work, is to visit the physicians in his county and stimulate interest in the preventive aspects of maternal and child health. Standards for maternal and child health work have been prepared by the respective committees of The Medical Society and will be furnished to each Field Physician. The family physician will learn under what circumstances he can obtain a nurse to assist at delivery, or a physician to act as consultant with him on obstetrical cases.

The Field Physician will also study the maternal deaths in his county, advise the county society in regard to maternity homes, arrange for obstetrical conferences, and develop opportunities for special courses in preventive obstetrics and pediatrics.

The Medical Society appreciates very highly

this plan of coöperation between the Medical Society and the Bureau of Maternal and Child Health of the State Department of Health. The execution of the plan should demonstrate to other States, to certain Foundations, and to the Federal Government, that the health of mothers and children can be safeguarded through evolutionary methods, and without any radical change in our present system of medical practice. For several years The Medical Society of New Jersey has had active committees on Maternal Welfare and Child Health. From their wealth of experience these committees have contributed chapters to the Handbook of Preventive Procedures, outlining the services which family doctors can render in these fields. The system of Field Physicians makes it possible for the State Medical Society and the Department of Health to establish and maintain intimate contacts with practicing physicians throughout the State.

By this evolutionary method, a responsible system of organized medicine, coöperating with a conscientious State Department of Health, is attempting to fulfill its obligation to the public.

CANNABIS INDICA PRESCRIPTIONS

The increasing use of cannabis, or marihuana, for its intoxicating effects has led Congress to attempt the control of its sale through a law which took effect on October 1, 1937. The law requires that every person who administers, prescribes, or deals in the drug shall register annually with a Collector of Internal Revenue, and pay a registration fee of one dollar each year. The object is not to raise money for the Government, but to provide the means for identifying the dispensers of the drug, and for preventing its use as a narcotic or intoxicant.

The forms for use by the doctor are similar to those for prescribing opium or any of its derivatives. It is hardly probable that any physician in New Jersey will have occasion to prescribe the drug; but if he does, he may obtain the necessary forms from the U. S. Customs House, New York City.

Cannabis has been used as an intoxicant in Southwestern Asia since the earliest days of history. It is the hemp plant from whose fibrous bark coarse cloth and rope are made, and whose seeds are fed to songbirds. Its intoxicating constituent is a resin that is found only in the pistillate flowers, but is absent in the ripe flower heads, the stalks, and the seeds of the plant.

The word *hemp* is the original word, *cannabis,* which has undergone a series of changes according to well-known laws of language,—cannabis, chanabis, hanapis, henep, hemp.

By another series of changes, cannabis becomes canavis, and then canvas,—the material from which bags and boat sails that were originally made from the hemp plant.

In Arabia the slang name for cannabis was *hasheesh,* meaning *hay;* and hence the word *assassin* or a murderer who committed the crime while intoxicated with cannabis.

The word *marihuana* is of Spanish-Mexican origin and originally meant tobacco; but it was finally applied to cannabis in the form of cigarettes prepared for smoking.

THE NEW HUDSON COUNTY TUBERCULOSIS HOSPITAL

On Wednesday, November 3, 1937, *The Jersey Journal* of Jersey City issued a thirty-six-page supplement describing the New Hudson County Tuberculosis Hospital, which was dedicated on November fourth. The supplement gives the history of the hospital, and the progress of anti-tuberculosis work in Jersey City and the rest of Hudson County.

The new hospital is a 500-bed unit of the Medical Center. The building was completed about a year ago at a cost of about $3,000,000. It will be opened for service next Spring after the installation of the equipment, costing about $750,000.

The hospital is under the direction of a Board of Managers, consisting of Dr. Frederic J. Quigley, President; Dr. George H. Sexsmith, Vice-President; Dr. George O'Hanlon, Superintendent of the Medical Center; and Mr. John F. O'Neill, County Supervisor.

The story of the development of anti-tuberculosis work from modest beginnings to its development into an outstanding system in the nation is described in several articles of the newspaper by heads of the departments.

Dr. Quigley described its origin and growth, and credited its inception to Dr. Gordon K. Dickinson, an outstanding surgical leader of

Jersey City. He was head of the committee which established the Laurel Hill Tuberculosis Hospital in 1907, which was the fifth of its kind in the United States. He remained President of the Board until his death in 1930. At that time he was planning a children's tuberculosis preventorium, which will complete the system of Hudson County.

The work of the several departments is described by their heads. Dr. B. S. Pollak, Medical Director of the Hospital, reviewed the history of anti-tuberculosis work in Hudson County during the thirty years of his active connection with it, beginning in February 1, 1907, when he made an examination of thirty-four patients assembled in the old almshouse. He was then commissioned by the Board of Freeholders to develop means for dealing with tuberculosis patients, and has grown up in the work, and is Chairman of the Tuberculosis Committee of The Medical Society of New Jersey. His leadership in demonstrating the importance and value of testing high school students for incipient tuberculosis has been an outstanding contribution to the control of the disease.

Dr. Abraham E. Jaffin, Chief of Clinic Physicians, related the growth of the Hudson County Clinic from its small beginning in a basement, to its present facilities for making every possible examination of a suspected patient, including x-ray and sputum tests.

The promotion of the morale of the inmates is an essential part of their treatment, especially in a hospital where their activities are necessarily restricted, and time passes with exceeding slowness. Fourteen years ago the patients themselves proposed to establish their own monthly publication. This was accomplished with the active assistance of Dr. Pollak, and its name "Smilin' Thru" was adopted as the slogan for every patient in the hospital. There has always been numerous writers among the patients and abundance of time for preparing their contributions. An example of their articles and of the spirit of the inmates is indicated by the following verses, slightly adapted from the original:

THE PATIENT'S VIEW

The doctor says, "Don't smoke or chew";—
  We don't.
He made it plain, if we want to gain,
We must not think of dope or drink;—
  We don't.
To stay up after nine is wrong.
Some guys may like their wine and song;—
  We don't.
We kiss no girls, not even one.
You would not think we have much fun;—
  We don't.
They say some patients growl and bite
And spurn their nurses exquisite;—
  We don't.
Our greatest fun, our heart's delight,
Is to get well with all our might.
And help the doctors win our fight.
  That's what WE do.

BOARD OF MEDICAL EXAMINERS

Following is a report of the Board's activities in enforcing the Medical Practice Act since our last report (Journal, June, 1937, p. 403):

February 9th, 1937, Josefa Kostowska, a licensed midwife of Jersey City, paid a penalty for continuing to practice midwifery after having failed to secure an annual certificate of registration.

February 12th, 1937, Harry Hirschorn, a licensed chiropodist of Newark, paid a penalty for continuing to practice chiropody after having failed to obtain an annual certificate of registration.

March 5th, 1937, Arthur H. Carrington, a registered pharmacist of Seaside Heights, pleaded guilty before the Judge of the Common Pleas Court of Ocean County to a charge of practicing medicine without a license.

March 9th, 1937, Victoria Kleczkowski, a licensed midwife of Jersey City, pleaded guilty to a charge of continuing to practice midwifery after having failed to secure an annual certificate of registration.

March 15th, 1937, Carmela Frascella, a licensed midwife of Trenton, paid a penalty for continuing to practice midwifery after having failed to secure an annual certificate of registration.

March 29th, 1937, Charles W. Remboy, an "Herb Doctor" of Butler, pleaded guilty to a charge of practicing medicine without a license. He refused to pay the penalty and was committed to jail for two hundred days. He had pleaded guilty to a similar charge on May 23rd, 1935. (Jour., Sept., 1935, p. 558.)

In April, 1937, Carrie Armstrong, of Burlington, who was treating foot ailments, paid a penalty for practicing medicine without a license.

April 18th, 1937, Leon Gross, of Audubon,

was found guilty of practicing medicine without a license by the Judge of the Camden District Court.

April 21st, 1937, the license to practice medicine and surgery of Abraham Benjamin was revoked.

June 1st, 1937, Bash Cruso, who was treating foot ailments in a shoe store in Jersey City, was found guilty of practicing medicine without a license by the Judge of the First District Court of Jersey City.

June 10th, 1937, Percy Ridout, an unlicensed chiropractor of Englewood, was found guilty of practicing medicine without a license by the Judge of the Englewood District Court.

June 15th, 1937, John E. Usher, a licensed chiropractor of Orange, who was practicing electro-therapy, pleaded guilty before the Judge of the First District Court of Newark to a charge of practicing medicine without a license.

June 18th, 1937, Israel Shmid, a naturopath of Lakewood, was tried before the Judge of the Common Pleas Court of Ocean County to a charge of practicing medicine without a license. After the State's case was presented, he pleaded guilty to the charge. He was found guilty of a similar violation by the Judge of the Somerville District Court on December 18th, 1929.

June 24th, 1937, Nathan H. Fleischner, a registered pharmacist of Englewood, was found guilty of practicing medicine without a license by the Judge of the Englewood District Court.

June 28th, 1937, Paul Piekarsky, a licensed chiropodist of Paterson, pleaded guilty to a charge of practicing medicine without a license, before the Judge of the First District Court of Paterson.

June 29th, 1937, Frank Sanduzzi, a registered pharmacist of Newark, was found guilty of practicing medicine without a license by the Judge of the First District Court of Newark.

June 29th, 1937, George Maza, an unlicensed chiropractor of Newark, was found guilty of practicing medicine without a license by the Judge of the First District Court of Newark and filed notice of appeal. He was found guilty on similar charges in 1925 and 1930.

June 30th, 1937, James N. Conroy, a registered pharmacist of Moorestown, paid a penalty for practicing medicine without a license.

In August, 1937, two licensed osteopaths of Union County, one of Atlantic and one of Camden, were arrested for practicing medicine without a license, and paid their penalties.

September 24th, 1937, Nicholas Farmakis, of Orange, who gave his patients medicine that he prepared, was arrested on a charge of practicing medicine without a license, and pleaded guilty. He pleaded guilty to a similar charge on August 22nd, 1935. (Jour., Sept., 1935, p. 558.)

September 28th, 1937, Lee Hanes, of Newark, was found guilty of practicing medicine without a license by the Judge of the First District Court of Newark. He was unable to pay the penalty and was committed to jail for fourteen days.

James J. McGuire,
Secretary.

PRACTICING PREVENTIVE MEDICINE

Dr. Stanley Nichols, Chairman of the Sub-Committee on Public Health, calls the attention of family doctors to their opportunities to progress in the practice of preventive medicine in two lines in which the State Society can be of essential help to them.

1. HEALTH SUPERVISION

The advisory committees are developing a series of five cards measuring 5 x 8 inches, on which the family doctor may keep a physical record of each patient throughout life. These cards are on the following subjects:

1. Maternal Health.
2. Infant Health.
3. Pre-school Age Health.
4. School-Age Health.
5. Adult Health Supervision.

2. GRADUATE EDUCATION

The committee is coöperating with the Committee on Graduate Education in providing three lines of education and practice:

1. Concise literature on common topics in preventive medicine. These are intended to be indexes to procedures.
2. Short training courses, as demonstrations of what to have in mind when making examinations and giving advice in incipient conditions of ill health.
3. More extensive training in hospitals, clinics and baby keep-well stations for those who wish to engaged more deeply in the practice of such branches as pediatrics, venereal disease control, tuberculosis detection and treatment, and other branches in which every general practitioner is expected to engage.

OBITUARY

LIVINGSTON L. LEWIS

Dr. Livingston L. Lewis, of 712 Washington Street, Hoboken, N .J., died November 9, 1937, from coronary thrombosis.

Dr. Lewis was born in Hoboken in 1877. He received his early education in the Public Schools of that city, and his medical education at New York University and Bellevue Hospital College, graduating in 1898. He served his interneship at St. Mary's Hospital in Hoboken, and had been a member of the staff ever since that time. He was lecturer and staff consultant at St. Mary's Hospital.

Dr. Lewis will be recorded in history as one of the martyrs of x-ray. He was one of the first to use it in treating disease before the dangers of handling it were known. In using x-ray he burned his left hand so badly that he was compelled to give up surgery and take up the practice of medicine.

At the outbreak of the World War, Dr. Lewis gave up his practice, one of the largest in Hoboken at the time, and went into the field. He served two years at Fort Hancock, Augusta, Ga., and was discharged with the rank of Major. He then resumed the practice of medicine.

Dr. Lewis was a member of the Association of Military Surgeons of the United States, American Medical Association, Medical Society of New Jersey, Hudson County Medical Society, Puritan Lodge, F. & A. M., of which he was a Past Master, and the First Methodist Episcopal Church of Hoboken.

He is survived by his wife, Mrs. Beatrice Van Zendt Lewis, and a son, Livingston L., Jr., a senior at Newark University.

LIST OF NEW JERSEY PHYSICIANS DYING IN OCTOBER

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Margaret M. Dassell	64	July 9, 1937	Amityville, L. I., N. Y.	Jersey City	Carcinoma of uterus.
Joseph G. Denelsbeck	72	Oct. 28, 1937	Trenton	Same	Chronic myocarditis.
James R. English	71	Oct. 24, 1937	General Hospital, Irvington	Short Hills	Cerebral hemorrhage.
Elizabeth Hupp	62	Oct. 11, 1937	Englewood	Same	Cerebral hemorrhage.
Leo Koppel	50	Oct. 13, 1937	Jersey City	Same	Myocarditis.
John T. Kufta	30	Oct. 8, 1937	All Souls' Hospital, Morristown	Boonton	Lobar pneumonia.
Hillard Lockwood	80	Oct. 25, 1937	Jersey City	Jersey City	Prostatism.
Louis T. Reed	78	Oct. 27, 1937	Somerville	Same	Broncho pneumonia.
Julius W. A. Schmidt	83	Oct. 22, 1937	Union City	Same	Chronic myocarditis.
Andrew B. Vanderbeek, Jr.	32	June 22, 1937	Knoxville, Tenn.	Paterson	Appendicitis.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS SINCE JULY 1, 1937

DIPHTHERIA TOXOID

County	Total to Sept. 30	Month of October	Total to Oct. 31	Average per Month
Atlantic	24	43	67	16.7
Bergen	333	438	771	192.7
Burlington	59	4	63	15.7
Camden	100	340	440	110.
Cape May	12	3	15	3.7
Cumberland	505	124	629	157.2
Essex	1033	598	1631	407.7
Gloucester	102	6	108	27.
Hudson	47	4	51	12.7
Hunterdon	2	3	5	1.2
Mercer	189	89	278	69.5
Middlesex	168	33	201	50.2
Monmouth	286	55	341	85.2
Morris	97	36	133	33.2
Ocean	21	0	21	5.2
Passaic	583	145	728	182.
Salem	49	224	273	68.2
Somerset	244	13	257	64.2
Sussex	1	0	1	.2
Union	310	86	396	99.
Warren	48	0	48	12.
Totals	4213	2244	6457	1614.2

SMALLPOX VACCINE

County	Total to Sept. 30	Month of October	Total to Oct. 31	Average per Month
Atlantic	327	110	437	109.2
Bergen	566	98	664	166.
Burlington	180	89	269	67.2
Camden	548	738	1286	321.5
Cape May	31	4	35	8.7
Cumberland	249	31	280	70.
Essex	1455	766	2221	555.2
Gloucester	262	66	328	82.
Hudson	55	7	62	15.5
Hunterdon	13	9	22	5.5
Mercer	164	304	468	117.
Middlesex	327	48	375	93.7
Monmouth	706	200	906	226.5
Morris	207	43	250	63.5
Ocean	5	0	5	1.2
Passaic	815	122	937	234.2
Salem	198	14	212	53.
Somerset	243	19	262	65.5
Sussex	0	0	0	0.
Union	1228	136	1364	341.
Warren	172	7	179	44.7
Totals	7751	2811	10562	2640.5

CONTACTS AND COMMENTS



"THE WARD YOU WANT IS DOWN FOUR FLIGHTS".

This maternal welfare reminder, drawn by B. Davis, is reproduced by permission from the November 14, 1937, issue of "This Week",—the Sunday Magazine Section of the New York Herald Tribune. We will not spoil the effect of the picture by attempting to apply its implications to actual practice.

It is with pleasure that we grant the permission asked by Mr. Ernest D. Easton, Executive Secretary of the New Jersey Tuberculosis League, Inc., in his following letter of appreciation:

In the November issue of The Jounal of The Medical Society of New Jersey, I note a comprehensive report of the League's annual meeting at New Brunswick, and an informal and discerning analysis of the anti-tuberculosis campaign in New Jersey.

On behalf of the League, I wish to express appreciation of the timely publication of these articles which I feel will be of great value in extending knowledge and understanding of our objectives among your membership. I should also like permission to quote these articles, entire or in part, in our various publications and press releases.

Dr. S. Bernard Kaplan, Newark, Chairman of the Section on Gastro-Enterology of The Medical Society of New Jersey, issues the following invitation:

An investigation for papers and presentation before the Gastro-Enterological Section of the Annual State Meeting in Atlantic City is given to all members of the State Society. Requests for presentation should communicate with the Chairman of the Section before the first of February. I hope that this will give every member of the State Society interested in Gastro-Enterology an opportunity in assisting in the success of this Section.

Bio-photometric tests are discussed in an erudite paper in *Public Health Reports* of October 8, 1937. The subject is becoming of practical importance because of the relation of vitamin deficiency to the acuity of sight. The article describes a method of testing the fatigue of the eye. The steps in the test are:

1. The patient sits in absolute darkness until the pigment of the eye attains its highest efficiency.
2. He then looks at a bright light for three or four minutes, or until the pigment is exhausted and the eye is "bleached".
3. He then looks at a series of dim lights, in order to determine the threshold of returning vision.

The measure of returning vision is indicated by the intensity of the weakest light which is perceived as recorded by an electric photometer.

The work is now in its experimental stage, but it is of interest to physicians who treat "Night blindness", or examine candidates for licenses to drive automobiles.

In accordance with its traditions for progress, the Bulletin of the Burlington County Medical Society of November says:

Our meetings, as they are now held, are more popular and satisfactory than they have ever been, and the increase in attendance and interest warrants that they be continued in the same manner. With the cost of these and the combined meeting with the Woman's Auxiliary, the Treasurer is just about breaking even this year; and if we are to continue on this same high standard, and have another meeting with the Auxiliary, which we should do, this year, an increase of two or three dollars in dues is unavoidable.

At its meeting on November 11, the society voted that its dues should be increased to twenty-five dollars (see Journal, page 755).

Discussing venereal disease control, the Bulletin says:

A nation-wide drive against syphilis is now getting under way, and written material will soon be

sent to every society member which will be helpful in renewing our ideas on treatment, and show how we can coöperate in this drive. In addition, our Program Committee should include a meeting devoted to the syphilis control and treatment problem with an invited authority on the subject, and take advantage of the offer made by the State Bureau of Venereal Disease Control to furnish movies, with machine and operator, free of charge.

The November issue of the Bulletin of the Essex County Medical Society contains a plea that its members support its own institutions and specialists. It says that every useful piece of medical equipment can be found in New Jersey; and therefore to send a patient to a consultant outside the State is unfair to the patient, because:

1. It undermines the patient's confidence in the adequacy of his own medical community.
2. It burdens the family with large fees and awkward traveling.
3. It deprives the local institutions and physicians of a wealth of clinical material and experience.
4. It stamps the local profession with the stigma of provincialism.
5. It feeds the pathetic and unfounded hope of unfortunate families in the magic of "big names".

The pathologists of New Jersey have formed the New Jersey Society of Clinical Pathologists with the following officers:

President, Asher Yaguda, M.D., Newark
Vice-President, Robert A. Kilduffe, M.D., Atlantic City
Secretary, A. J. Casselman, M.D., Camden
Treasurer, A. J. Casilli, M.D., Elizabeth

SUPPLEMENTARY REPORTS AT THE ANNUAL MEETING

It is planned that no supplementary reports shall be *read* at the Annual Meeting of the House of Delegates; but since reports are written a month before the Annual Meeting, supplementary material that is absolutely necessary may be submitted to the Executive Offices up to a week before the meeting; and it will be mimeographed and copies sent to every delegate and to the members of the reference committees.

This plan will speed the proceedings of the House, and promote the interest of the members in the transaction of business. The House of Delegates is not primarily a lecture forum or an investigating body; but its function is to *take action* on subjects which have been *studied previously*.

DRY ICE A HEALTH HAZARD

A warning about a danger to health from "Dry Ice" (carbon dioxide in solid form) is contained in the November 8th issue of *"Health News"*,—the weekly publication of the New York State Department of Health. The article refers to a report of a case in the *Journal of the A. M. A.*, March 20, 1937. The patient, a boy aged seven, was admitted to Mt. Sinai Hospital, New York City, for edema of the larynx caused by the accidental inhalation of a bit of dry ice which he held in his mouth in order to "Blow off steam". He recovered after tracheotomy. He and other boys got the ice from ice-cream vendors.

"Health News" also refers to a report in the October, 1937, issue of *The Health Officer*, published by the U. S. Public Health Service. Several large boys at a picnic amused themselves by placing a lump of dry ice in a tightly-corked bottle, and watching it blow up. A premature explosion resulted in the death of a boy who was preparing a bottle.

THE MEDICAL CORPS OF THE NAVY

An examination of candidates for appointment as Lieutenant (junior grade) in the Medical Corps of the Navy will be held at all Naval Hospitals in the United States and at the Naval Medical School, Washington, D. C., beginning May 16, 1938.

Candidates for admission must be between the ages of twenty-one and thirty-two years at time of appointment, graduates of Class "A" medical schools, and have completed an internship of one year in a hospital accredited for interns by the American Medical Association and the American College of Surgeons.

Those who are interested should write the Surgeon General, U. S. Navy, Bureau of Medicine and Surgery, Navy Department, Washington, D. C., for further information in regard to the examination and the procedure to follow for them to appear before one of the Examining Boards.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING METINGS

DECEMBER, 1937				JANUARY, 1938			
7	Hudson	10	Atlantic	4	Camden	18	Warren
7	Camden	10	Salem	4	Hudson	19	Middlesex
8	Mercer	14	Bergen	11	Bergen	20	Gloucester
8	Ocean	14	Cumberland	12	Mercer	20	Morris
8	Union	15	Middlesex	12	Ocean	25	Hunterdon
9	Burlington	16	Gloucester	13	Burlington	26	Monmouth
9	Essex	16	Morris	13	Essex		Sussex (at call
9	Passaic	22	Monmouth	13	Passaic		of President)
9	Somerset			14	Atlantic		

ATLANTIC COUNTY

E. H. Nickman, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held November 12, 1937, at the Ambassador Hotel, Dr. James H. Mason, Vice-President, presiding in the absence of the President, Dr. H. S. Read.

SCIENTIFIC

The scientific program, "The Man of Fifty", was presented by Dr. J. G. H. Beardsley, Professor of Medicine, Jefferson Medical College, Philadelphia, Pa. Brief discussions were presented by Drs. Allman, Salasin, Carrington and Kilduffe.

BULLETIN

Dr. J. C. Brown reported that the Supplement to the Bulletin was undergoing a revision process, and would reappear with the Bulletin when it was completed.

VENEREAL DISEASE

The Venereal Disease Control Committee of the State Society has recommended that county societies appoint their own Venereal Disease Control Committees, and devote at lesat one meeting to this project. Suitable motion pictures are available through the State Society.

MATERNAL NURSING HOMES

The maternal nursing homes now existing in the county were approved.

PUBLIC RELATIONS

The State Society Public Relations Committee has prepared Bulletins on various subjects to be used as aids in preparing addresses to be given before lay groups.

The Underwriter's Service Bureau of Washington, D. C., which purports to appoint insurance examiners, was exposed as a "racket", and it was suggested that their letter be turned over to the postal authorities for their information.

BIRTH CONTROL

It was announced that the State Society Medical Advisory Committee recommends that a meeting of each County Society be devoted to Birth Control, the speaker to be provided by the State committee.

A letter from Walter D. Ulrich, Insurance Adjuster, with reference to the fee charge for tetanus antitoxin administration was voted received and filed.

CONSTITUTION AND BY-LAWS

Following the report of Dr. W. W. Hersohn on the revision of the Constitution and By-Laws, a motion was made and passed to accept the Articles of Incorporation, which will replace the original Constitution, and to furnish copies of the By-Laws as revised to each member of the society before the next regular meeting.

A motion was made and passed to give the Officers and Board of Trustees the authority to sign the articles of incorporation and to change the seal of the society to include "Inc., 1937".

NEW MEMBERS

Drs. Clifford K. Murray, S. H. Holmes, I. Stalberg, J. H. Scott and A. M. Rechtman were unanimously elected to membership.

BABY KEEP-WELL STATION

Dr. V. E. Johnson, reporting for the Public Health Committee, stated that an appointee should be made to the Baby Keep-Well Clinic of the Northside. He recommended that a recognized pediatrician be appointed; and a member of the Atlantic City Medical Association be appointed to serve with the pediatrician until he becomes familiar with the procedures to be carried out.

IMMUNIZATIONS

A motion was passed to accept recommendations of the Public Health Committee with reference to smallpox and typhoid vaccination and diphtheria immunization in adults and children.

WORKMEN'S COMPENSATION

Following a report of the Workmen's Compensation Committee by Dr. Abraham Krechmer, a recommendation was made that this society go on record as in favor of the plan of the State Society committee.

ESSAY CONTEST

Dr. C. B. Kaighn, reporting for the Public Relations Committee, stated that the Woman's Auxiliary was sponsoring an essay contest on "The Prevention of the Common Cold" by all children of Junior High School age.

MEDICAL-DENTAL BUREAU

Dr. Harley, reporting for the Medical-Dental Bureau Committee, recommended the approval of the Professional Arts Credit Association by the society. As this is a purely commercial enterprise, the motion was lost.

BERGEN COUNTY

LeRoy W. Black, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held in the new Administration Building at Bergen Pines, on Tuesday, November 9th. Dr. Charles Littwin, our President, in his opening speech noted this was the first meeting in the newly completed Administration Building at Bergen Pines, and that we were particularly honored by having not only the officers and members of our neighboring Rockland County Medical Society of New York, officers of the Passaic County Medical Society, and many officers of The Medical Society of New Jersey, but also by having Dr. Frank Lahey, of Boston, as our distinguished guest speaker.

VACANCY IN BOARD OF TRUSTEES

Dr. H. B. Wilson announced that there was a vacancy on the Board of Trustees of The Medical Society of New Jersey due to the unfortunate death of Dr. Blase Cole, and moved that the Bergen County Medical Society recommend Dr. Samuel Alexander, of Park Ridge, to the vacancy. This was passed unanimously.

NEW MEMBERS

Applications for membership were read as follows: From junior to regular, two; to regular, one; to junior, three.

The following were elected to membership:

From Junior to Regular—
Dr. Frederick S. Leonard, Jr., Tenafly
Dr. Sarah Gordon, Teaneck
Dr. Nelson C. Policastro, Hackensack
Dr. John Scillieri, Hackensack

To Junior—
Dr. E. J. Salva, Palisades Park
Dr. Charles Richard D'Amato, East Rutherford
Dr. S. Calthrop Bump, Ridgewood

SCIENTIFIC

Dr. Walter J. Farr introduced Dr. Frank Lahey, of Boston, who spoke upon "Thyroid Diseases". Dr. Lahey showed slides demonstrating:

1. Eye conditions due to exophthalmos in hyperthyroidism and myxedema.
2. Exophthalmos in children.
3. Thyrocardiac conditions.
4. Thyroid crises.
5. Laboratory and experimental data with hippuric acid, serum proteins, blood iodine and blood cholesterol in relation to basal metabolic readings and thyroid diseases, and
6. Adenomatous conditions of the thyroid.

The paper was discussed by Dr. F. W. Bancroft, of New York, and Dr. F. C. McCormack.

MEDICAL SOCIETY SPEAKERS

Dr. E. Zeh Hawkes, First Vice-President, Medical Society of New Jersey, spoke upon the activities of the State Society.

Dr. Frederic J. Quigley and Dr. Spencer T. Snedecor, Past Presidents of The Medical Society of New Jersey, spoke upon the situation arising from the action of the 430 prominent physicians who recommended federal subsidy of medical schools and medical care.

BURLINGTON COUNTY

Parry M. Scott, M.D., Reporter

The 108th annual meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club on November 11, 1937. In the absence of President Small, the meeting was called to order by Vice-President Fahrenbruch at 9:30 p. m.

SCIENTIFIC

Vice-President Fahrenbruch then turned the meeting over to Dr. Howard Curtis, Chairman of the Committee on Program, who introduced the speaker of the evening, Dr. Arthur Bingham, Chairman of the Maternal Welfare Committee of the State Society. Dr. Bingham gave a most instructive talk on "Informal Discussion of some Practical Obstetrical Problems". His remarks were discussed by Dr. Walter Mount, and then a short general discussion followed.

VENEREAL DISEASE CLINIC

The Secretary in his report read two letters, one from Dr. A. J. Casselman and one from Dr. LeRoy Wilkes, assuring the society that the Venereal Disease Clinic is to be established at the Zurbrugg Memorial Hospital and would be in operation as soon as possible.

EXECUTIVE COMMITTEE REPORT

The Executive Committee recommends:

1. That the Burlington County Medical Society endorse Mantou testing of school children and adults along the lines as suggested by the Detroit Plan, to be done by the family physician in his office, and to be paid for at the rate of $1.00 per test, coming from an appropriation from the Board

of Chosen Freeholders, if such an appropriation can be obtained; and that a committee of three in addition to the Chairman of the Tuberculosis Division of the Public Health Committee be appointed to present this plan to the Board of Freeholders.

2. That a communication from Dr. C. B. Blaisdell in reference to Venereal Disease Control be referred to the Chairman of the Committee on Program and arrangements.

The recommendations of the Executive Committee were adopted.

NEW MEMBERS

Dr. Ruben Frank and Dr. Freeman W. Metzer were received into full membership.

TUBERCULOSIS

Dr. Marcus W. Newcomb explained the Detroit Plan for testing school children and adults, and following his remarks, Vice-President Fahrenbruch appointed the following committee to present the plan to the Board of Chosen Freeholders: Marcus W. Newcomb, Chairman; Richard D. Anderson, Harry L. Rogers, S. Emlen Stokes.

DUES

The Treasurer reported that the State Society assessment per capita had been raised this year from $13.00 to $15.00, and if we were to continue the meetings in their present popular form an increase in dues of $2.00 or preferably $3.00 would be necessary. After a short discussion a motion was made, duly seconded and carried that the dues for the coming year be fixed at $25.00.

ELECTION

On the report of the Nominating Committee, the following officers were elected:

President, Frederick D. Fahrenbruch
Vice-President, Charles Munro
Secretary, E. Warren Rodman
Treasurer, E. Vernon Davis
Reporter, Carleton P. Hogan
Censor, R. D. Anderson

Delegates to the State Society: Arthur Peacock, Emlen P. Darlington, S. Emlen Stokes, J. Howard Hornberger

Alternates: Hammell P. Shipps, Daniel Remer, Edward Hunter, Dean H. LeFavor

Member of the Nominating Committee of State Society: S. Emlen Stokes; Alternate, E. P. Darlington

President Fahrenbruch made the following appointments for the year of 1937-1938:

Chairman Committee on Program and Arrangements
Parry M. Scott

Member of Executive Committee, Roscius I. Downs, 1940

Welfare Committee and Legislation
Harry L. Rogers, Chairman
John S. Conroy Russell D. Geary

Public Health Committee
Cancer—Hammell P. Shipps, Chairman
Tuberculosis—Marcus W. Newcomb
Mental Hygiene—Ralph Gladen
Maternal Welfare—Howard C. Curtis
Crippled Children—E. Vernon Davis
Venereal Disease Control—Robert R. Imhoff
Child Health—Harry B. Mark

Maternal Welfare and Birth Control
Frederick D. Fahrenbruch, Chairman
Hammell P. Shipps Howard C. Curtis

Constitution and By-Laws
Ephraim R. Mulford, Chairman
Harry B. Mark Joseph M. Kuder

Post-Graduate Education
Howard C. Curtis, 1938 Parry M. Scott, 1939
Arthur B. Peacock, 1940

Medical Defense
George T. Tracy, Chairman
Joseph Stokes J. Howard Hornberger

Public Relations
Joseph M. Kuder, Chairman
Richard Anderson J. Howard Hornberger

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The monthly meeting of the *Camden County Medical Society* was called to order by the President, Dr. J. Lynn Mahaffey, at 9 p.m., November 2nd, 1937.

NEW MEMBERS

New members were elected as follows:
Lewis R. Thompson, Pine Hill, N. J.
Paul G. Ebner, Camden, N. J.

PUBLIC HEALTH COMMITTEE

The Public Health Committee presented a form of standing orders for the Metropolitan Nurses for the County Society's approval, which was given. The committee was also asked to draw up a resolution urging the city and county authorities to clear up the pollution of the Cooper River.

SCIENTIFIC

The scientific meeting was one of the most interesting of the year. Dr. Thomas M. Kain gave a masterly presentation of "Serum in the Treatment of Pneumonia". The results of his treatment should be an inspiration to every general practitioner to avail himself of this form of therapy.

Dr. Robert A. Reimann gave a splendid discussion. His main theme was that serum treatment was of proven worth, and that the doctors should begin to use it before the public demands that they do.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

President H. Roy Van Ness of the *Essex County Medical Society* introduced Dr. William G. Herrman, President of The Medical Society of New Jer-

sey, as the principal speaker at its meeting Thursday evening, November 11, 1937, at the Academy of Medicine, Newark.

PRESIDENT HERRMAN'S ADDRESS

Dr. Herrman assailed the "mistaken point of view" of 430 physicians in the nation who took a stand in favor of socialized medicine. He said in part, "If we do allow such dissension in our ranks to be publicized and taken advantage of by those who, with a mistaken point of view, would wreck American medicine in order to please the public at large, we will find ultimately they have lowered the standards of medicine and health of the people by having forced upon us European methods which have caused a higher amount of sickness and a lower grade of medical care received by the public wherever it has been instituted."

Reviewing the names of the 430 physicians, Dr. Herrman said:

"I am glad to say that not a single resident of New Jersey is numbered among them. Many of the signers are institutional men, teachers in medical schools, or full-time employees of large institutions, and cannot help but have a different point of view from that of men in the field."

Conceding that the *indigent* must be cared for, Dr. Herrman said he felt the word must be carefully defined, as it was the common experience of physicians that patients who drove cars and spent money on cosmetics declared they couldn't afford to pay doctors' bills. He urged a system similar to that which prevailed under the *Emergency Relief Administration,* whereby indigent patients chose their own physicians on a reduced fee basis, and the profession, not the government, was in control.

There were proper fields for government activity in medicine, he said, naming health of military service and police groups, care of war veterans' disabilities, epidemics, occupational and contagious diseases, insanity, epilepsy and research.

"No governmental activity in medicine should come without approval of the profession," he said. He opposed compulsory health insurance; and also governmental subsidy of medical schools, which, he said, would mean that the government could dictate what theories should be taught and who should be admitted.

"If it were true that life's necessities should be socialized and distributed on the basis of need rather than the ability to pay," he said, "then food and shelter, as more primary needs even than medicine, would logically have to be socialized first. The heavy price of regimentation would have to pay for any such goals."

POLIOMYELITIS

Dr. Ellis L. Smith, Chairman of the Committee on Poliomyelitis and Medical Director of the Essex County Isolation Hospital, spoke on acute poliomyelitis, surveying the present knowledge of the disease and stressing the important current highlights.

PNEUMONIA SERUM

Dr. Theodor Teimer, Chairman of the Public Health Committee, reported that his committee was working to advance the treatment of pneumonia with serum, saying that in certain cases where the proper and specific serum was used promptly the mortality was reduced fifty per cent.

He reported that at a conference on November 1st between Drs. Craster, Connolly, Tarbell, and himself the committee sought the coöperation of the Newark Health Department in a program of pneumonia control. Dr. Craster had independently outlined a program at the same time this committee became interested. It is his desire, however, to coordinate his work and ours. He has placed the Newark Health Department squarely behind our efforts and has made the following offer:

1. The Newark Health Department will provide day and night facilities in its own laboratory for typing pneumonia cases, and will accept the results of typing done in other reputable laboratories.

2. The Department will provide messenger service to pick up sputum specimens at the request of any physician; and will type them and report promptly to the physician concerned.

3. If desired by the physician, the Department will provide a nurse or other competent person to secure a sputum specimen, when so ordered.

4. Free serum will be provided to all Newark residents having types I or II pneumonia, provided they are financially eligible for this assistance.

5. Serum of the proper type will be delivered to the patient's bedside by the same messenger service that will collect specimens.

6. Trained collaborators will be available to assist the physician administer the serum, if the physician so requests.

7. The following limitations will be imposed on the provision of serum as experience in other cities has shown that they are essential:

a. Every case must be typed before serum can be provided.

b. The patient's illness must not have been more than four days.

8. In order to assist the medical profession and the Health Department to evaluate the use of serum, the Health Department requests a full clinical report of the results of such serum treatment be supplied to it by the attending physician.

NEW MEMBERS

The following physicians were elected to membership:

Regular members—

Bacote, Ernest F., Newark
Brandman, Otto, Newark
Citrino, Robert J., Nutley
Fink, A. Elston, Newark
Geller, Samuel, Newark
Mendelson, Abraham, Newark
Selvaggi, Carlo, Newark
Simon, Harry, Newark
Solk, Arthur G., Newark
Sturchio, Edoardo, Newark

Associate members—

Barrett, John E., Newark
Ciarla, Filimeno Peter, Millburn
D'Angelo, Joseph Carl, Belleville
De Luca, Donato, Newark
Eisenberg, Harry, Belleville
Holmes, Dwight O. W., Jr., Newark
Inge, Hutchins F., Newark
Lieb, Saul, Newark
Luippold, Eugene John, Jr., South Orange
McCluskey, Harry B., East Orange
Nussbaum, Harvey E., Newark
Pollock, Franklyn J., Newark

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The *Gloucester County Medical Society* held its regular monthly meeting on the evening of Wednesday, November 18. Dr. Tooker was cordially welcomed after his serious illness last summer.

SCIENTIFIC

Dr. C. H. deT. Shivers, urologist to the Atlantic City Hospital, gave an address on "Prostate Hypertrophy", and outlined a method of grouping cases for operation.

Members present from Woodbury were Drs. Diverty, Underwood, Brewer, Rogers, Crain, Downs, Moore and Paul Burkett.

Westville, Drs. Hollinshed, Patterson, Campo, Booth; Paulsboro, Drs. Wood, Sheets and Sinexon; Gibbstown, Drs. Ulmer and Gairdner; Swedesboro, Dr. Livingood; Pitman, Drs. W. J. Burkett, Lummis, Knight, Barrows and Wright; Wenonah, Dr. Weems; Clayton, Drs. Wandall and Gillis; Mantua, Dr. Ruttenburg; and Williamstown, Dr. Fooder.

Guests included Dr. Shivers, of Atlantic City; Dr. Broselaw, of Franklinville; Dr. Collins, of Glassboro; Dr. Sirotta, of Paulsboro; and Dr. Serri, of Mullica Hill.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular monthly meeting of the *Hudson County Medical Society* was held on Wednesday, November 3, 1937, at the Carteret Club, and was called to order by the President, Dr. W. L. Williamson, at 9:30 p.m.

SCIENTIFIC

Dr. Williamson introduced Dr. W. G. Herrman, President of The Medical Society of New Jersey, who spoke on the subject "State Activities".

Dr. Williamson then introduced Dr. Z. Bercovitz, Associate in Medicine, New York Post-Graduate Medical School, Columbia University, whose subject was "The Diagnosis and Treatment of Ulcerative Colitis". The discussors were Drs. Pearlstein and Perkel.

REPORT OF SECRETARY

The following communication was received by Dr. T. McG. Brennock, Secretary:

"As one of the steps in our participation in the nation-wide drive against syphilis, each county society has been asked to appoint a committee, composed of its best qualified men, to act as a Venereal Disease sub-committee of its Public Health Committee. Many counties have already done this. If you haven't, will you please ask your President to appoint, with the Chairman of the Public Health Committee, these men at this time, and let me have the name and address of the chairman?

"Will you also please ask your Program Committee to include, if possible, a meeting devoted to the Syphilis Control and Treatment Problem, inviting or selecting your own best authority, a speaker for the occasion? Consult also the State Bureau of Venereal Disease Control about the free movies you can have, with the latest films with machine and operator provided on the night you desire it.

"In a matter involving so much public interest, it is important that our profession be both alert to its responsibilities, as well as equal to them. Evidence that has many times been in the hands of health officers and courts handling delinquent cases shows a weakness in the treatment routine of many individual physicians.

Written material will soon be sent to every society member, helpful in renewing his ideas on treatment, or showing how he can coöperate in this present drive against an old enemy. Coin your own squibs for your monthly Bulletin and get your members thinking.

"C. B. Blaisdell, *Chairman*,
"State Advisory V. D. Committee."

PUBLIC HEALTH COMMITTEE

Dr. Williamson appointed Dr. Sidney Chayes, of Bayonne, to fill the vacancy on the Public Health Committee caused by the resignation of Dr. Howard Forman.

BY-LAWS

Dr. Brennock, Secretary, read the following change in the By-Laws:

"The following change in the By-Laws, Chapter IV, Section 10, is submitted governing the Committee on Public Health:

"The Committee on Public Health shall consist of eighteen members, who shall be *appointed by the President,* each to hold office for three years. They shall be so appointed as to represent the various municipalities of the County. Upon the adoption of this By-Law, six members shall be appointed for three years, six for two years, and six for one year. Three new members shall be appointed each year. The committee shall elect its own Chairman."

This was referred to the Constitution and By-Law Committee.

NEW MEMBERS

Dr. Sidney R. Arbeit, 2521 Boulevard, Jersey City
Dr. Urban R. Bigliani, 526 36th Street, North Bergen
Dr. Emmanuel Ricciardelli, 75 Linden Avenue, Jersey City
Dr. Eli Scheer, 5316 Boulevard, North Bergen

Transfer from Bergen County Medical Society:

Dr. Rubin Grossman, 416 Boulevard, Bayonne

Three new members were proposed.

The meeting adjourned at 10:55 p.m.

MONMOUTH COUNTY

O. R. Holters, M.D., Reporter

A meeting of the *Executive Committee of the Monmouth County Medical Society* was held at the Fitkin Memorial Hospital, Neptune, on Monday evening, October 11th, with the following members present: Drs. Parry, Moffat, Clark, Albright, Magee, Gosling, Kazmann and Featherston.

REFUND OF DUES OF NEW MEMBER

The matter of refunding the dues of a member was discussed and referred to the office of the State Treasurer. He was elected to membership in May and moved to Brooklyn recently, and feels that in view of the fact that the society did not function during the summer months, he derived no benefit from his membership. As the greater portion of his dues were sent to the State Treasurer, the matter was referred to Dr. Elias Marsh with the recommendation that his request be granted.

A letter of appreciation was received from the American Zeppelin Transport Company, New York, which was ordered to be read at the next meeting. (Jour., Oct., 1937, p. 642.)

The regular monthly meeting of the *Monmouth County Medical Society* was held at the Berkeley Carteret Hotel in Asbury Park on Wednesday evening, October 27th, at 8:30 p.m., with an unusually large attendance.

SCIENTIFIC

Dr. Burrill B. Crohn, of New York City, presented "Diagnosis and Treatment of Sudden Gastric Hemorrhage". The paper was given extemporaneously, and was one of the best of the current year. It was discussed by Dr. Victor Knapp, Dr. Harry B. Slocum, Dr. Walter Rullman, and others.

The Fitkin Hospital has added to its already very modern equipment another Drinker respiratory apparatus, the so-called iron lung.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A recreational meeting of the *Morris County Medical Society* was held the evening of Thursday, November 18, at the Spring Brook Club in Morristown, with approximately 150 present, composed of members and their wives and friends.

President Williams introduced the entertainer of the evening, Mr. Paul Klugh, recently moved to Summit, New Jersey, from Chicago, who had retired from business and since then had spent most of his time traveling through distant parts of the world and penetrating at leisure remote regions by various modes of transportation to obtain unusual still and movie "Shots" of animal and human life, and of natural and man-made objects of interest and instruction.

Mr. Klugh's travelogue and narrations covered the Islands of the Southern Pacific Ocean and the Orient, revealing much of the hitherto unknown and unseen, and provided an evening of interesting and instructive value.

OCEAN COUNTY

Harry S. Ivory, M.D., Reporter

The regular monthly meeting of the *Ocean County Medical Society* was held on Wednesday evening, October 13, 1937, at Eno's in Forked River, with Dr. W. G. Hayden presiding as president. Those present were Drs. Bunnell, Dodd, Goldstein, Halbach, Hayden, Herbener, Ivory, Menge, Obert, Sawyer, Sickel, Taylor, Tilles and Towbin.

COLLECTING BILLS

Dr. Hayden presented a brief summary of the Executive Committee meetings held during the summer. Dr. Bunnell, who had been appointed chairman of a committee to further the collection of physicians' bills in Ocean County, reported on the activities of the committee. Dr. Bunnell advanced a plan which later came to be known as the "Bunnell Plan", the essential features of which were as follows:

1. That a Physician, Dentist, and Hospital Bureau of Ocean County be formed;

2. That a full-time collector be employed by the Bureau to collect all bills of the individual members which may be not less than three months in arrears;

3. That a small book containing a triplicate statement of each account be made for use of: (a) the Bureau, (b) the collector, (c) the bureau member;

4. That each Bureau member be assessed a small fee to pay for the system;

5. That the coöperation of all physicians be obtained;

6. That a committee composed of representatives of the physicians, the dentists, and the hospitals be appointed to meet with the collector once a month;

7. That the collector provide each Bureau member with a written report on the status of his bills once per week.

In discussion, Dr. Hayden stated that complete coöperation of all doctors would be necessary to insure the success of any such plan. Dr. Hayden then called upon each member present for an expression of opinion on this subject. Dr. Halbach then moved that the Ocean County Medical Society go on record in favor of the adoption of some collection plan, the details of which to be evolved later; and that the Secretary notify all members before the meeting at which a final decision on the final plan is made. Dr. Menge seconded this motion and it was carried.

NEWSPAPER PUBLICITY

A series of bulletins containing material on health subjects suitable for presentation to the laity was received; and the advisability of publishing this and other similar data in the newspapers of Ocean County was discussed. It was moved, seconded and carried that Dr. Obert, Secretary of the society, be authorized to give the newspapers of Ocean County the copies sponsored by the New Jersey State Medical Society and the American Medical Association for publication each week.

SPEAKERS' BUREAU

Dr. Towbin moved, it was seconded and carried that a Speakers' Bureau be formed to offer the services of various members of the society to service clubs, parent-teacher associations, and similar organizations. Dr. Herbener moved, it was seconded and carried that a Speakers' Bureau Committee be formed. Dr. Hayden appointed on this committee Drs. Goldstein, Halbach, and Dodd.

HOUR OF MEETING

The question of changing the time of our meetings from 6:30 or 7 p.m. to 9 or 9:30 p.m. was brought up by Dr. Ivory. After some discussion, Dr. Sickel moved that the next three meetings be called for 9 p.m. to try out this idea. The motion was seconded by Dr. Dodd and carried.

PRIVATE PRACTICE BY U. S. NAVAL OFFICERS

The question of government medical officers practicing among the civilian population, particularly by the Lakehurst Naval Air Station physicians, was discussed at some length. Dr. Taylor moved that the society communicate with the Surgeon General of the Navy in Washington to ascertain the official attitude on this matter. The motion was seconded by Dr. Menge, but it was decided to table this motion temporarily. Dr. Sawyer moved that the physicians at Lakehurst be invited to our next meeting to express their views on this subject. Dr. Ivory was appointed to approach the Lakehurst Naval Senior Medical Officer, Commander Collins.

VISITATION BY STATE OFFICERS

A communication was received from Dr. W. G. Herrman, President of The Medical Society of New Jersey, requesting a list of convenient dates for his visitation to our society.

WOMAN'S AUXILIARY

A communication was received from the Woman's Auxiliary of our society requesting that an Advisory Board be appointed in accordance with the By-Laws of the Woman's Auxiliary of the New Jersey State Medical Society. Dr. Hayden appointed Drs. Buerrman, Ivory and Obert to this Advisory Board.

NEW MEMBERS

The credentials of Dr. William Earl McIlvains, 104 Third Street, Lakewood, for transfer from the Bergen County Medical Society to the Ocean County Medical Society were reecived. It was moved, seconded and carried that Dr. McIlvaine be made a full member in good standing in the society.

Dr. C. R. Schneider, Tuckerton, N. J., was made a full member of the society.

WORKMEN'S COMPENSATION

The following recommendations by Dr. Halback were discussed, without action:

1. That all compensation cases requiring hospital treatment be notified by the hospital that they have the privilege of having in attendance any physician they may wish;

2. That a standard fee system be formulated for each community, and that all infringements be referred to the Censor's Committee.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on Thursday evening, November 11, 1937, at the Passaic City Club. The President, Dr. Frank Vosburgh, presided.

CONSTITUTION AND BY-LAWS

Many changes in the Constitution and By-Laws were read and approved. These changes will bring the form of organization into conformity with that of the State Society, and were principally as follows:

1. Providing four forms of membership, emeritus, active, associate, and courtesy.
2. Waiving dues for special causes.
3. Adopting the State Society's form of organization of the committees, sub-committees, and advisory committees.

A change in the Constitution was then read by Dr. Yager, the Secretary, extending eligibility to membership to include physicians doing exclusively public health work, or institutional practice, such as pathologists.

MATERNAL WELFARE

Dr. Theodore K. Graham, Paterson, Chairman of the Maternal Welfare Committee, reported several meetings of the committee, and that the first round-table discussion on obstetrical problems would be held at St. Joseph's Hospital, Paterson, some time in December. Dr. Bingham, Chairman of the State Maternal Welfare Committee, has promised to lead the discussion at that time. As Field Physician, Dr. Graham reported that between July, 1936, and July, 1937, he had visited 250 physicians in the county. He had visited all the hospitals, and that all had accepted the rules for the care of obstetrical patients as outlined by the State Committee. He had sent a complete report to the State Committee of all hospital activities for the year 1936. He had had many calls for nurses and consultations. This work was discontinued July 1, 1937.

Since October 1st of this year Dr. Graham has been Field Physician for Child Welfare, and he asked further coöperation from the physicians.

WORKMEN'S COMPENSATION

Dr. MacBride reported that the Committee on Workmen's Compensation has met and is studying the situation, and hopes to have a final report for the next meeting.

CONTROL OF VENEREAL DISEASE

Dr. Hall reported that a series of lectures on the treatment of venereal diseases would start at the Paterson General Hospital the last Tuesday of November. Notices would be sent out later. He asked for volunteer speakers to address lay groups, and said that next month activities for the public would be taken up.

CANCER COMMITTEE

Dr. Shapiro submitted an expense account, the total of which was $501. He asked for the approval of this, and said that the Society was now associated with the American Society for the Control of Cancer.

Dr. Willard moved and Dr. Spickers seconded a motion that the expense account be approved. This was passed.

A rising vote of thanks was given Dr. Shapiro and his committee for their tireless efforts and fine results during Cancer Week.

OBITUARY

A resolution of sympathy on the death of Dr. William C. Cantrell, of Clifton, N. J. was read and passed. A copy will be sent to Mrs. Cantrell.

NEW MEMBERS

The following new members were elected:

Junior to Active Membership—
George A. Bradasch, Haledon
Francis B. Brogan, Paterson
Byron H. Close, Bloomingdale
Louis Cohen, Passaic
Harold C. Geiger, West Milford
John E. Leach, Paterson
Abraham Simkin, Passaic

Transfers from Other County Societies—
Francis H. DeGrace, Passaic, from Nassau County
William M. Kennedy, Passaic, from Essex County
Solomon H. Pink, Butler, from Morris County

SCIENTIFIC

Dr. Joseph Buchman, Assistant Clinical Professor in Orthopedic Surgery, New York University Medical College, spoke on the "Diagnosis and Treatment of Osteomyelitis". He discussed the etiology, the anatomy, the pathogenesis, and the clinical picture of acute hemotogenous osteomyelitis; and closed with an exhibition of lantern slides of patients and the methods of their treatment.

SALEM COUNTY

L. C. Hummel, M.D., Reporter

The November meeting of the *Salem County Medical Society* was held at the Salem County Memorial Hospital November 12th at 3 p.m., with Dr. C. B. Mackes presiding.

Delegates to Camden, Gloucester, and Cumberland Counties were elected.

Two applicants were elected to membership in the society, Dr. L. R. Silverman and Dr. R. C. Sutherland, both of Pennsgrove, N. J. One application for membership was received. The Membership Committee is apparently functioning, and it is with much pleasure we welcome the new men to our society.

The Program Committee reported they had completed their list of speakers for the coming meetings, and it would seem from the program that we are to have one of the most interesting and helpful years in our history.

STANDARDIZATION OF FEES

Drs. Green, Hummel and Suter were appointed as a committee for establishing a standard of fees for the Salem County Society.

VENEREAL DISEASE CONTROL

A committee to act as a Sub-Committee for Venereal Disease Control was appointed. Drs. F. H. Church, H. F. Suter and C. S. Davison were appointed to this committee.

SCIENTIFIC

A very instructive paper was given by Dr. Robert Gamon, of Camden, N. J., on the treatment of varicosities. Dr. Gamon spoke on the history of the injection treatment, and the difficulties encountered up to the present time. He gave a very practical talk which should be of help to many of the men using injection treatment.

One of the most encouraging signs of the meeting was the enthusiasm shown by the members over the coming meetings, and the manner in which the several committees are functioning. Our society is small, but a determined effort is being made to get all the doctors in the county to join it. The interest and work shown by each individual member is a most healthy sign, and a promise of a good year.

UNION COUNTY

Ronald J. Walsh, M.D., Reporter

The annual meeting of the *Union County Medical Society* was held at Muhlenberg Hospital, Plainfield, on October 13, 1937, at 9 p.m., with a large attendance. The President, Dr. E. P. Weigel, of Plainfield, presided.

DR. J. B. HARRISON'S BIRTHDAY

A letter of birthday congratulations sent to Dr. Joseph B. Harrison by the Society, and his reply thereto, were read. Dr. Harrison has been a member of the Union County Society for sixty years, and in that time he has never missed a meeting of the State Society. (Journal, May, 1937, p. 342.)

VENEREAL DISEASE CLINIC

Dr. T. J. Walsh for the Special Committee on Appointment to the Venereal Disease Clinic, stated that the names of Dr. A. Rose and Dr. D. Lieberman had been recommended.

FINANCES

Dr. S. T. Quinn made a favorable report for the Finance Committee, and informed the society that the dues for 1938 had been set at twenty dollars, with a credit of five dollars to those members who had paid the assessment of five dollars toward the Medical-Dental Service Bureau.

CHILD HYGIENE

Dr. Frederic W. Lathrop, Chairman of the Child Hygiene Committee, made his report, the highlight of which was that the appropriation had run out, and that physicians working in the clinics would have to do so, for the time being, on a non-remun-

erative basis. He urged that even under these unfavorable conditions, it would be much better for the profession to control the situation by keeping in charge of the clinics, and thus prevent bureaucratic domination.

PUBLICATION COMMITTEE

Dr. L. B. Armstrong, for the Publication Committee, reported that several physicians had complained that they had not received notice of the time and place of meetings. He pointed out that this information is clearly printed in each issue of the society's bulletin. Dr. Armstrong then asked that errors in addresses should be rectified as soon as possible.

MEMBERSHIP COMMITTEE

Dr. W. B. Morris, reporting for the Membership Committee, gave some interesting figures. Out of 353 practicing physicians in the county, there are forty-six non-members; or over 12 per cent of the whole. Of these, four have applied for membership. There is a total of twenty-three delinquent members; twenty-one of these have been approached, and nine have agreed to return to good standing. In spite of these efforts, however, said Dr. Morris, the non-member list is far too great, and he asked the President to appoint a committee to contact all these gentlemen and seek to bring about their entrance to the society.

MEDICAL-DENTAL SERVICE BUREAU

Dr. T. J. Walsh, reporting for the Medical-Dental Service Bureau, gave a mildly encouraging outlook for the project. The Bureau has run at a slight profit for the past eight months; this was largely due, however, to the income derived from the collecting of over $12,000 in old bills. Dr. Walsh deplored the lack of general support on the part of the profession, stating that only about four per cent of the members took advantage of the facilities of the bureau. He urged members of the Society to increase their patronage with regard to old and delinquent accounts as well as new business.

PUBLIC RELATIONS

Dr. C. H. Schlichter reported for the State Welfare Committee. Dr. Burritt of the Public Health and Relations Committee, said that the State Committee had asked that our society should volunteer speakers to address adult educational groups on medical topics of general interest. Further action is to be taken in this matter.

Dr. Salvati made a short, spirited address asking for harmony, and the abandonment of the policies detrimental to the welfare of the Society as a whole.

PRESIDENT'S ADDRESS

The President's Address to the society followed. He spoke briefly of the events of the past year, and gave constructive advice on the problems of next year. (This address is printed in The Journal of October, page 653.)

ANNUAL ELECTION

The officers for 1938 were elected as follows:

President, Henri E. Abel
Vice-President, Rowland P. Blythe
Secretary, Lorrimer Armstrong
Treasurer, Alden R. Hoover
Reporter, Ronald J. Walsh
Trustee, J. B. Harrison
Censor, M. A. Shangle

Public Health and Legislation Committee, George S. Laird

Delegates to the State Conventions for three years to 1940:

Delegates	*Alternates*
Henri E. Abel	Walter Phelan
C. A. Brokaw	H. C. Stillwell
N. W. Burritt	N. W. Currie
J. G. Boyes	Isadore Stein
R. J. Walsh	Maxwell Ehrlich
R. N. Nittoli	A. J. Drury
M. H. Stein	E. M. Staub

Finance Committee, three years: N. V. Hubbard

Committee on Scientific and Literary Program: George Stein, J. A. Lepree, J. M. Lyerly

Committee to Medical-Dental Bureau to 1940: Jack Blumberg, Elmer P. Weigel

State Nominating Committee: Edward Kranz
Alternate, W. J. Hallock

Summit Medical Society

E. H. Macpherson, Secretary

The regular monthly meeting of the *Summit Medical Society* was held Tuesday evening, October 26th, at the Nurses' Home of Overlook Hospital in Summit. The meeting was called to order by the President, Dr. Tidaback, with thirty members and ten guests present.

A resolution was adopted that a committee of the Summit Medical Society meet with a committee of the Summit Board of Health to consider the venereal disease problem.

Dr. Tidaback presented Dr. Elmer P. Weigel, of Plainfield, the Attending Orthopaedic Surgeon on our staff, who gave an illustrated talk on "Fractures of the Hip". He stated that many of our best efforts in the treatment of fractures of the hip have not been satisfactory. He gave the history of the various methods used, including the Smith-Peterson nail for fixation of the hip, which is a satisfactory means of internal fixation. The Moore method with the fixation by pins was also described.

Dr. Weigel for the past two years has used pins inserted directly through the skin. An x-ray must be obtained in two planes. At times the Kirschner wire is used in conjunction with the pin method. The patient remains in bed for a week or two and then is allowed to sit in a chair. It is most important that the patient should not be rolled over in bed. Some cases require four or five weeks in Russell traction. Usually an operation is done under spinal or local anesthesia, but local anesthesia is not satisfactory due to the pain on reduction.

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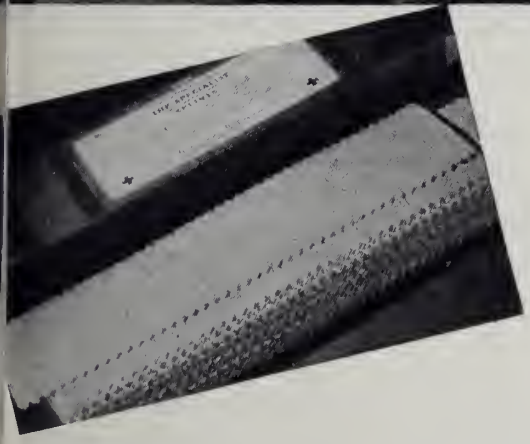
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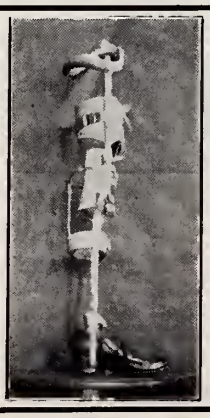
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THE FAMILY DOCTOR

IN

PREVENTIVE MEDICINE

AND

PUBLIC HEALTH

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A HANDBOOK OF PROCEDURES

Suggested by

THE ADVISORY COMMITTEES OF

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Edited by

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Editor of The Journal of The Medical Society of New Jersey

137 East State Street, Trenton, N. J.

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THE FAMILY DOCTOR IN PREVENTIVE MEDICINE AND PUBLIC HEALTH

A Handbook of Procedures

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Director of Health of New Jersey

FOREWORD

SPENCER T. SNEDECOR, M.D.,
President of The Medical Society of New Jersey

This Handbook of Procedures in Medicine and Preventive Public Health is dedicated to the Family Doctor, alert and earnest, who will practice modern **preventive** medicine in equal proportion with curative treatment and surgery.

It should be read with forethought by every physician, because within its pages he will find a sketch of many methods and procedures, approved by The Medical Society of New Jersey, that go to make up good medical practice of today. The standards which are outlined will demonstrate to the patients and public health officials the intensely vital place which the Family Doctor has in preventive medicine.

This Handbook will stand as a tribute to the especially able Chairman of the Public Health Committee of The Medical Society of New Jersey, Dr. Stanley Nichols, who has served faithfully and efficiently for the past several years. Both we as physicians, and the public at large, are indebted to him much more than we generally realize, for arousing an up-to-date public health consciousness in the minds of the doctors of New Jersey.

May we use this Handbook as a guide to the realization of Dr. Nichol's slogan—

Every Physician's Office in New Jersey a Health Center for the Practice of Preventive Medicine.

CHAPTER ONE

THE FAMILY DOCTOR

LeRoy A. Wilkes, M.D., Executive Officer

Contacts
Availability of Information
Leadership of the Family Doctor
Basis of Experience

THE EXECUTIVE OFFICES

During the three years of their operation, the Executive and Editorial Offices of The Medical Society of New Jersey have filed and digested the records which previously had been retained by the individual officers and committeemen, and have made them readily available, so that each new group of officers may build intelligently and progressively upon the foundations laid by their predecessors. This service has also been extended to the County Medical Societies, thereby promoting unity of action and efficiency of execution.

The Executive and Editorial Offices have also made possible the establishment and maintenance of intimate contacts with Departments of Health and Welfare, and with voluntary organizations engaged in promoting health in all its phases. They are also promoting agreements with these organizations regarding their respective fields of service, beginning with those whose services are State-wide, and extending later to those whose activities are confined to the counties, and to the local administrative units.

THE MEDICAL SOCIETY THE ADVISER OF HEALTH ORGANIZATIONS

The result of this centralization of medical information and administration has been the increasing recognition of The Medical Society of New Jersey as the medical adviser of State-wide health organizations; and of the county society as the medical consultant of those health associations whose fields lie within their respective counties.

THE FIELD OF THE FAMILY DOCTOR

The next logical development will be to enlarge the field of the Family Doctor as the medical adviser of his families in all phases of medical service, preventive as well as curative. In order to promote this most desirable objective, The Medical Society of New Jersey has authorized the preparation of a Handbook which lists and defines the services which the Family Doctor must be prepared to render, but which have often been left to clinics conducted under the auspices of Departments of Health and Voluntary Health Organizations.

This Handbook does *not* attempt to inform the Family Doctor regarding the principles of the practice of medicine, for he already has that knowledge, as is attested by his license to practice medicine and his membership in the medical society of his county and State. Rather it deals with the newer *methods of delivering* his services.

ECONOMIC CONDITIONS OF PATIENTS

Every call which the Family Doctor makes involves an economic transaction between the Family Doctor and his patient. He carries a stock of knowledge, skill, and physical equipment sufficient to deal with ninety-five per cent of all conditions of disease and health; and in the remaining five per cent he may obtain assistance from a biological laboratory or a Department of Health; or a consultant, as in the diagnosis of diphtheria, or in a maternity case of unusual difficulty.

If the patient does not have the equipment for carrying out the doctor's directions, the Family Doctor will advise him *how* it may be secured through the services offered by hospitals and welfare and social agencies, as indicated in this Handbook.

EMOTIONAL STATES OF PATIENTS

In addition to economic resources, patients require a hopeful outlook on life in order to insure their efficient utilization of medical services. It is a common expression among physi-

cians that "You can't do anything for that family",—meaning that the heads of the families lack the initiative, energy, and persistence to carry out those necessary procedures which may be called "personal" services. The Family Doctor's judgment and cheer encourage the patient and bring out unsuspected endurance and bravery which are often life-saving. His field includes the mind and the soul as well as the body of the patient; and in the hours and days between his visitations, the service rendered by visiting nurses and representatives of welfare organizations and churches are of essential value in maintaining the morale of the patient.

It is an essential part of the services of the Family Doctor to develop the body of a weakened person into a self-sustaining organism, working under its own power, overcoming the obstacles of stormy sickness, emotional weakness, and soul starvation. In this work of rehabilitation, the Family Doctor can utilize the services of voluntary organizations, provided he gives to each worker a specific prescription which applies to the individual patient.

BASIS OF EXPERIENCE

All the procedures that are enumerated in this Handbook have grown out of experience, and have been discussed in the meetings of the Welfare Committee, and those of its several sub-committees, particularly that on Public Health, under the chairmanship of Dr. Stanley Nichols, to whose initiative and leadership the plan of this Handbook and its composition are due. The novelty of this Handbook is that it is a compilation of the suggested procedures, rearranged and rewritten from the point of view of the *Family Doctor* rather than that of the specialist in public health, or of administrative organizations,—medical, official, or lay,—which are engaged in promoting public health measures.

The greatest asset of any successful enterprise is the confidence and good-will of its patrons. Most persons judge the entire Medical Profession by their Family Doctor. If *he* delivers the services which his patient needs, or acts as the personal agent of the patient in obtaining them, the scientific practice of medicine in New Jersey will be on a basis that is satisfactory to the people and to the Medical Profession.

LeRoy A. Wilkes, *Executive Officer.*

CHAPTER TWO

ORGANIZATION FOR PUBLIC HEALTH WORK

Hilton S. Read, M.D., Atlantic City, Chairman, Welfare Committee

System of Organization,—Trustees and Committees
Welfare Committee
Sub-Committees
Advisory Committees on Public Health
Chart on Relationships

This Handbook contains suggestions to the *Family Doctor* of New Jersey in his relations to the practice of Public Health, especially its *preventive* phases. In order to understand these relations, it is desirable to describe the system of organization which has been adopted by The Medical Society of New Jersey for the delivery of services for preventing disease and promoting health.

SYSTEM OF ORGANIZATION

The House of Delegates. The Medical Society of New Jersey is a federation of the twenty-one county medical societies of the State. Its supreme governing body is its House of Delegates, which meets once a year and is composed of its elected officers, and about 200 representatives of the county societies, allocated according to the number of their members.

Board of Trustees. During the intervals between the annual meetings of the House of Delegates, the Board of Trustees has charge of the policies and finances of the State Society; the appointment of committees and of officers to fill vacancies; and acts in emergencies.

Standing Committees. In the administration of its *internal* affairs,—particularly its routine contacts with its members,—the State Society acts through eight standing committees, as follows:

1. Scientific Work.
2. Program and arrangements (Annual Meeting).
3. Publication (the monthly Journal).
4. Finance and Budget (auditing and paying bills).
5. Honorary Membership.
6. Hospitals and Medical Education.
7. Medical Defense.
8. Insurance, (malpractice), (sickness, and automobile).

WELFARE COMMITTEE

In the administration of its *external contacts,*—which include all phases of the practice of medicine—the State Society acts through its *Welfare Committee,*—a committee unique among the official State Medical Societies. This committee was organized in 1921, under the chairmanship of Dr. Wells P. Eagleton, of Newark, who was elected President of the Society in 1923, and ever since has been active in promoting its affairs. It consists of a minimum of thirty-five members, among whom each county society shall have at least one representative. The Committee now consists of fifty members, having exercised its constitutional prerogative in petitioning the President to appoint additional members for the period of unprecedented requirements.

SUB-COMMITTEES

The activities of the Welfare Committee are apportioned among four Sub-Committees, as follows:

1. Public Relations.
2. Legislation.
3. Medical Practice.
4. Public Health.

The Sub-Committee on *Public Relations* was instituted in 1935. Among its objectives are the developing of a system of *popular medical education;* the expounding of the Society's aims to other groups engaged in public health work; and the interpreting of the philosophy of The Medical Society of New Jersey to the people of the State. Dr. J. H. Kler, of New Brunswick, is its present Chairman.

The Sub-Committee on *Legislation,* under its present Chairman, Dr. B. S. Pollak, of Jer-

sey City, has supervision of the relations of the medical profession to the enactment of health laws by the State Legislature.

The details of the work of the Sub-Committee on *Medical Practice,* of which Dr. Thomas K. Lewis, of Camden, is Chairman, are assigned to six *Advisory Committees:*

1. Contract Practice, R. L. Sharp, M.D., Camden, Chairman.
2. Hospital Relationships, Thomas K. Lewis, M.D., Camden, Chairman.
3. Medical Care of the Indigent, C. H. Schlichter, M.D., Elizabeth, Chairman.
4. Nursing and Nursing Education, A. Charles Zehnder, M.D., Newark, Chairman.
4. Tuberculosis, Dr. B. S. Pollak, Jersey City, Chairman.
5. Cancer Control, Dr. Henry B. Orton, Newark, Chairman.
6. Venereal Disease Control, Dr. C. H. deT. Shivers, Atlantic City, Chairman.
7. Mental Hygiene, Dr. James S. Plant, Newark, Chairman.

The personnel of the Welfare Committee, its four Sub-Committees, and the thirteen Advisory Committees is listed on pages iv and v of each issue of The Journal, and contains the names of 115 individuals, a few of whom serve on two or more committees. These committees and their relations are shown in Chart 1.

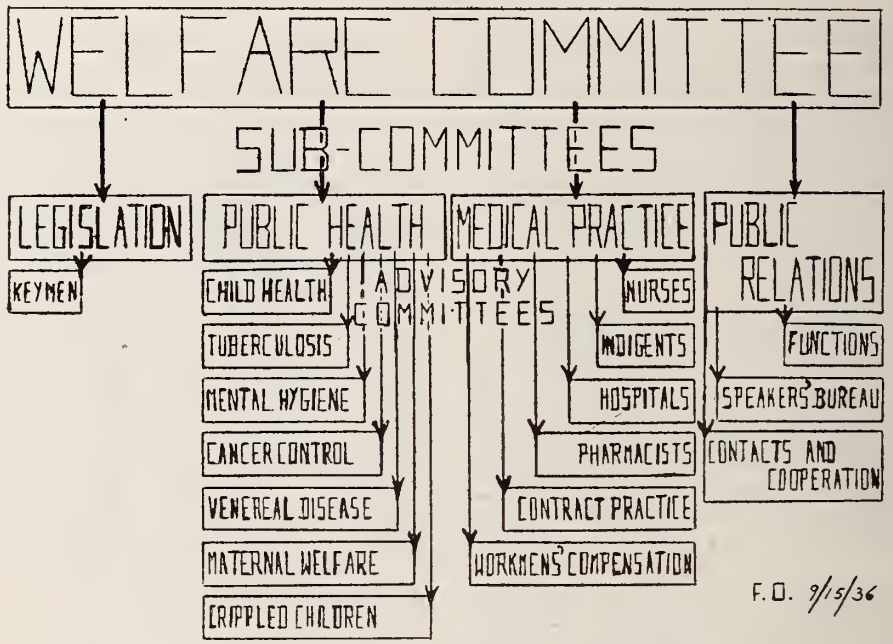


Chart 1.—The Welfare Committee, and its sub-committees, with their Advisory Committees.

5. Pharmaceutical Problems, Chester I. Ulmer, M.D., Gibbstown, Chairman.
6. Workmen's Compensation, J. Irving Fort, M.D., Newark, Chairman.

SUB-COMMITTEE ON PUBLIC HEALTH

The activities of the Sub-Committee on *Public Health,* Dr. Stanley Nichols, of Asbury Park, Chairman, are officially assigned to seven Advisory Committees, as follows:

1. Maternal Welfare, Dr. Arthur W. Bingham, East Orange, Chairman.
2. Child Health, Dr. Stanley Nichols, Asbury Park, Chairman.
3. Crippled Children, Dr. Elmer P. Weigel, Plainfield, Chairman.

The several chapters of this Handbook are the fruit of the experiences of each committee in planning public health activities; the observations of the results attained by the several methods of their execution; and suggestions for their application in the immediate future. The Handbook contains the contributions of many authors, some that have been written as formal reports and published in The Journal; and some verbal; but all have been assembled and coördinated under one editorishp. Each chapter has been submitted to its appropriate committee, and has received its approval.

For the development of standard methods which are adopted to both the Family Doctor and the Department of Health, a large share

of credit belongs to Dr. Julius Levy, Director, Division of Maternal Welfare and Child Health of the New Jersey Department of Health.

In addition to the contributions of the members of the Advisory Committees, two additional chapters have been prepared on specialties which are not yet represented on the formal list of Advisory Committees:

1. An informal chapter on the *physical examination of adults* under the chairmanship of Dr. Francis H. Glazebrook, of Morristown, based on his broad experience as Medical Director in examining the members of the New York Stock Exchange and its staff, representing a cross-section of the same class of leaders who are to be found in every community, and who will be the most likely to appreciate similar examinations by Family Doctors.

2. A chapter on *Communicable Diseases,* under the direction of Dr. J. Lynn Mahaffey, Director of Health, Department of Health of the State of New Jersey, dealing with the common communicable diseases which come under the official control of the State Department of Health. This chapter emphasizes the activities of Family Doctors as unofficial health officers, acting in coöperation with the Department.

The Welfare Committee recognizes the essential value of these two chapters in rounding out a complete medical service in preventive medicine.

This Handbook is printed as a supplement to the March, 1937, issue of The Journal. Let each member of The Medical Society of New Jersey preserve his copy with care, and refer to it frequently in his private practice along public health lines. By doing this he will do his part in accepting the implied challenge of the great health endowments and the leaders in social security movements, and will demonstrate that the practicing physicians of New Jersey can and will provide efficient medical service in all fields of preventive medicine and public health.

HILTON S. READ, *Chairman,* Atlantic City

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CHAPTER THREE

FUNDAMENTAL PRINCIPLES

STANLEY NICHOLS, M.D., Asbury Park, Chairman, Sub-Committee on Public Health

Forms of Medical Practice.
Preventive Medicine, and Public Health Contrasted
Clinics, and personal service.
Physicians, Medical Societies and relations of public health agencies.
Leadership of the Family Doctor.
Recipients of his preventive services.
Agreements among health workers.
The Detroit Plan.
The New Jersey system.
Age groups.

FORMS OF MEDICAL PRACTICE

The practice of the healing art by educated physicians has been recognized as a public necessity since the dawn of history. The science and art of medicine has reached such a high degree of development that physicians now classify themselves according to a triple basis:

1. Scientific attainments.
2. Freedom of action.
3. Degree of sickness (or health) of their patients.

1. On the basis of their scientific attainments, physicians are classed as:

a. General practitioners.
b. Specialists.

About three-fourths of the physicians of New Jersey are general practitioners, with stable clienteles who are proud of their "Family Doctors".

2. According to their individual freedom of action, physicians are divided into two classes:

a. Those in private practice.
b. Those in public health service.

The essential distinction between these two groups is in the manner of their engagements, —private practitioners being chosen and paid by the individual patients, while most doctors doing public health work as a specialty are appointed and paid by a third party who is the intermediary between the doctors and the patients whom they treat.

3. According to the degree of sickness—or health—of their patients, physicians render two classes of service:

a. Curative.
b. Preventive.

The majority of the physicians of New Jersey are *Family Doctors,* who make their living by their *private practice* of *curative medicine.* Every physician also renders daily service in *public health,* by practicing some form of *preventive medicine* at the same time that his major service is along curative lines.

The older fields of service of the Family Doctor and the Public Health Worker may be illustrated by a diagram of two separate circles,—one representing the Family Doctor practicing only *curative medicine,* and the other representing the Public Health Physician employed by the Department of Health to practice *preventive medicine.* These fields of service now overlap, as is shown in Chart 2, largely

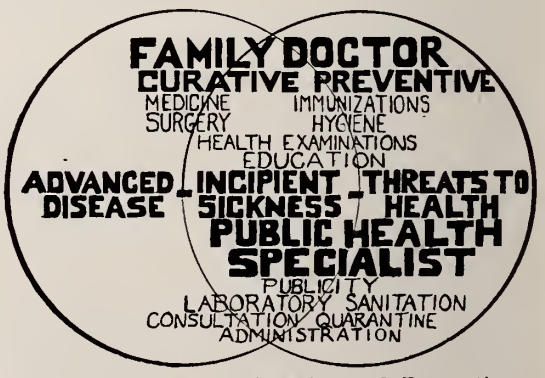


Chart 2.—Fields of Curative and Preventive Medicine and of Public Health.

because the development of medical science enables the Family Doctor to diagnose and treat diseases in their incipient stages; and also to

immunize well persons against many forms of sickness. The Family Doctor therefore enters the field of the Public Health Practitioner; and at the same time he uses the services of the laboratories and consultants of the Department of Health in the diagnosis and treatment of certain forms of sickness, such as communicable diseases and cancer.

PREVENTIVE MEDICINE AND PUBLIC HEALTH

The respective fields of service of Preventive Medicine and Public Health may be defined as follows:

The services of *Preventive Medicine* (immunizations, health examinations, early diagnosis, etc.) shall be prescribed for each individual by the Family Doctor, and be delivered by him, or under his direction, with the cooperation of other agencies (health departments, visiting nurses, voluntary associations, etc.)

The services of Public Health (sanitation, quarantine, milk inspection, etc.) shall be delivered by Departments of Health, with the cooperation and support of other agencies,—medical, official, and voluntary.

The former sharp distinction between private practice of medicine and public health procedures, and between the curative and the preventive services of medicine, is rapidly becoming obliterated by mutual agreements among workers as to their respective functions. Yet some degree of distinction between private and public health practice still persists, largely because individual citizens are unwilling to go to the trouble and expense of calling on a physician for protection against a health threat unless it is immediately at hand and is plainly evident to the ordinary person.

The State employs experts to perform those functions which are predominantly for the benefit of the public, such as controlling epidemics of infectious diseases, and promoting sanitary measures,—services which are largely *impersonal* and *compulsory*. These services are administered wisely and effiicently by Public Health specialists; and the Family Doctor is willing to leave the field to Departments of Health.

PERSONAL HYGIENE

There still remains the great field of *personal hygiene,* or the promotion of the practice of health measures by each individual citizen acting *voluntarily* rather than under *compulsion* by the official public health practitioner. This is a field of *personal* service which can be delivered efficiently only by the Family Doctor.

In the field of *personal hygiene,* the public health official is essentially an *educator* who instructs the people by public measures, such as pamphlets, newspaper articles, the radio, and lectures. In this work the services of local public health nurses, and social workers are of great importance. However, the actual delivery of the purely medical services which they advise devolves upon the Family Doctor. The public health workers recognize that principle by their reiterated advice—

"Consult your Family Doctor."

CLINICS

People generally do not realize the importance of the immunizations and health examinations which they may obtain from their Family Doctor. Departments of Health, Welfare, and Education, and Voluntary Health Associations are therefore inclined to establish public clinics and to stimulate the attendance of the people by offering the following inducements:

1. Free service.
2. A special campaign to popularize the clinic.
3. Free transportation to and from the clinic, and often refreshments and an entertainment.

The answer to health clinics, under ordinary conditions, is that Family Doctors shall be ready to make examinations and give immunizations and treatments *in their own offices,* and as a part of their private practice. This is the object of the "Public Health Hour" which is being promoted by The Medical Society of New Jersey. Clinics may be necessary in emergencies, or for educational purposes; and under these conditions the proper course to follow is that the county medical society, or a local representative group of physicians shall plan and direct them, and shall assign the doctors who deliver the medical services.

A clinic conducted under the auspices of the Medical Society may be made a valuable means of instructing its members in procedures in preventive methods and public health.

Permanent clinics are often established and maintained as *public health centers.* The objective toward which The Medical Society of New Jersey is pressing is—

"Every Doctor's Office a Health Center."

CHARTS

The routes of the daily calls of a physician radiate for miles from his office, and each professional visit is likely to reveal a problem which is novel and unsuspected. The Family Doctor is accustomed to dealing with emergencies, and keeps himself prepared to deal

with every condition of disease or accident which he is likely to meet. Public health problems are seldom emergencies except in outbreaks of communicable diseases and devastating calamities such as floods, fires, and epidemics; and so the people are inclined to delay consulting their Family Doctor about public health matters until they are aroused by an epidemic, or by a drive to bring patients to a clinic. It is therefore necessary that the Family Doctor should be a *salesman,*—at least to the extent of informing the public of the benefits of the public health services which he offers.

The charts in this Handbook are *road maps* which indicate the courses of the Family Doctor to follow in delivering his services in each line of public health work. They indicate the routes to his objectives, and his relations to landmarks along the way, and his contacts with other travellers and workers with whom he associates on the road to health.

DEVELOPMENT OF PUBLIC HEALTH AGENCIES

The principles of the relations of physicians to their patients is shown in Chart 3.

vidual person who was sick. Yet it is important to remember that in the earlier days a physician was the adviser to the *entire family,*—the well and the sick. He was in truth the *Family Doctor,* and understood the health characteristics and "Constitution" of every member of the family, from the new-born child to the aged grandfather.

ACCESSORY SERVICES

The old-time Family Doctor had no trained assistants to do his hard routine work for him. He was his own pharmacist in his "Doctor Shop", and prepared and dispensed his own medicines. His nurses were kind neighbors who took turns in "sitting up" with a sick patient, and whom he instructed as to their duties. The system of professional nurses and technicians, public hospitals and clinics, as shown in Chart 3, were products of a later date, whose tendencies have been toward *impersonal* service rendered for a price. Their weakness was, and still is, the lack of *personal touch* which characterized the assistants of the Family Doctor of the early days.

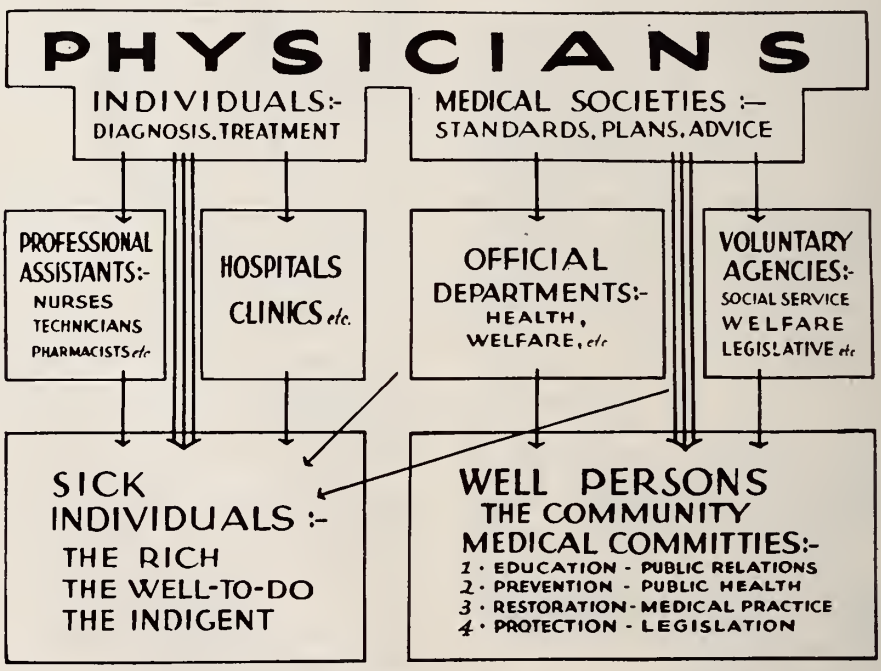


Chart 3.—Relations of Physicians to Patients, and of Medical Societies to the Community.

The left half of the chart shows the relations as they existed for a century after The Medical Society of New Jersey was founded in 1766. During that century medical service consisted in *individual practice,* in which a Family Doctor delivered medical service to an indi-

THE COUNTY MEDICAL SOCIETY AS THE MEDICAL ADVISORY OF THE COMMUNITY

A knowledge of the nature of communicable diseases and the means of their prevention has brought with it a necessity for *community action,* in which every Family Doctor takes part

as the local director, each in his particular group of private patients, who collectively comprise the entire community. This action is the prerogative and duty of *organizations of physicians,*—specifically the *county medical societies.* These societies, through their officers and committeemen, are the *medical advisers of the community,* as is indicated in the right half of Chart 3, page 14. Their community activities are a development of those of the old-time Family Doctor in his rôle as medical adviser of *the family.* A modern community is one great family whose members gather together in crowds, unaware of the new health threats which accompany the advantages that community life brings to the individual.

The county medical society speaks and acts through its official representatives, who plan its projects and activities, and make agreements with other organizations and with government officials regarding the scope of their public health work.

The county society also develops standards of the public health relations of its members, and the methods of their activities. When a physician says that he is speaking and acting according to the principles of the *medical profession,* he really means that the *county medical society* has taken formal action in regard to the matter.

Family Doctors are realizing more and more that it is to their own interest to advise the families of their patients in regard to immunization and other public health activities that are promoted by their county societies, for by this means they will regain those patients whom they have lost to clinics, public health nurses, dietitians, welfare workers, psychologists, and other agencies who do not have the practical point of view of the Family Doctor.

THE RELATION OF THE FAMILY DOCTOR TO THIS HANDBOOK

This Handbook is written from the standpoint of the *Family Doctor.* It advocates a return to the old system when a physician was the trusted doctor of an entire family for year after year. He took a personal interest in the health of each of its members, young and old, and advised them in *preventive* measures which have stood the test of time and experience. Whatever may have been his deficiencies in a knowledge of modern diagnosis and treatment in the past, he was strong in his homely advice along preventive measures as he understood them. The Family Doctor and his County Medical Society have the opportunity to reclaim their dominant position in public health, which was the prerogative of the Family Doctor in earlier days.

THE LEADERSHIP OF THE FAMILY DOCTOR

The Family Doctor is the center around whom the whole system of public health agencies in New Jersey revolves. The members of the system are indicated on chart 4:

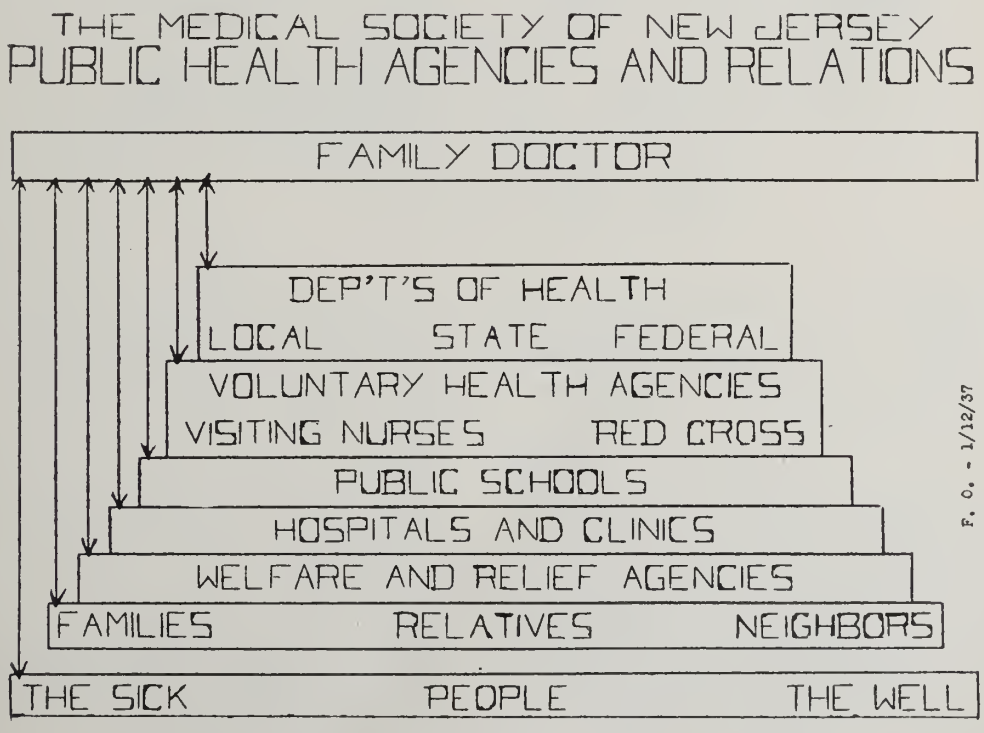


Chart 4.—Health agencies with whom the Family Doctor is in contact.

Medical service is delivered to the people by a practicing physician, whose finest exponent is the Family Doctor.

Between the Family Doctor and the people there are groups of agencies, beginning with the members of the family of the sick person and his neighbors, and running through various grades and fields to Departments of Health and the Federal Government. The connecting link between these service groups and the community is the Family Doctor or his county medical society.

The detailed relations of the Family Doctor to public health are indicated in Chart 5.

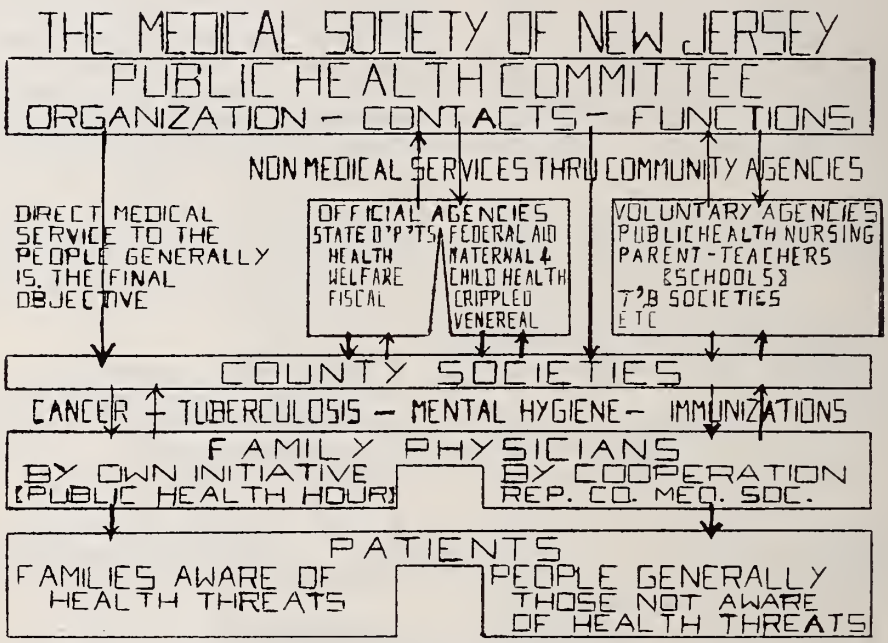


Chart 5.—The Family Doctor in his relationships to patients and The Medical Society of New Jersey.

The recipients of the services of public health and preventive medicine may be divided into two groups:

1. Those persons who are *aware* of health threats, and call upon their Family Doctor for preventive advice.

2. Those who are *not aware* of health threats, and must be influenced to seek, and even to accept, the services of preventive medicine that is offered by the Family Doctor.

Family Doctors and their county societies may call upon public agencies, both official and voluntary, to assist them in arousing the public generally to accept the protective measures, and to pay for them. The Public Health Committee of The Medical Society of New Jersey is the coördinating body between the Family Doctor and the lay groups engaged in public health work.

AGREEMENTS AMONG HEALTH WORKERS IN NEW JERSEY

Each group,—the medical and the lay, the welfare and the social, the official and the voluntary,—is equipped to do its own work better than any other group can do it. There have been disagreements in the past and a misapprehension of the peculiar field of service that belongs to each group. The non-medical groups, both voluntary and official, have always recognized the necessity that physicians shall deliver the services of medicine; but they have sometimes failed to contrive plans which were suited to the prevailing methods of medical practice. Rather they seemed to expect practicing physicians to conform to methods which were devised by laymen, impractical though they may sometimes have been.

The welfare groups have had the advantage of huge funds of "Endowments" donated for specific propaganda. It is true that some of the endowments had been offered to State and county medical societies; but the donations had usually been declined because of the restrictive conditions of the gifts. However, all the various groups, including physicians, are now disposed to lay aside their former preferences and prejudices, and to work in harmony and with

mutual understanding, each doing the work for which it is best fitted. One of the major objects of this Handbook is to indicate how all the health agencies may work together under the leadership and direction of the Family Doctor and his professional organizations.

THE DETROIT DEMONSTRATION

The health officials of a modern city now realize their dependence on the Family Doctor as the adviser of the people in all public health measures; and on the other hand, the Family Doctors are realizing their own responsibility to act not only individually, but also collectively through their county medical societies. The Health Department of the City of Detroit, under the leadership of its Commissioner, Dr. Henry F. Vaughan, has taken the members of the Wayne County Medical Society into its confidence. Practicing physicians are now beginning to accept the principle that "The office of every doctor shall be a health center" which is open to all those to whom he is the Family Doctor. The Detroit system of health department service exemplifies the advantages of the old-time system,—that every Family Doctor shall be the adviser of his families in all matters of preventive medicine and public health, as well as in their disabling sickness.

The place of the county medical society in the Detroit system is that of the agent of its members in devising methods of health administration in which individual physicians take the leading part in the delivery of the services.

THE NEW JERSEY SYSTEM

The Medical Society of New Jersey has patterned its system of health administration after that of Detroit, in which the Family Doctor is the center. In order to emphasize the essential place of the general practitioner of medicine in the health service of a community, the words *Family Doctor* are capitalized throughout this Handbook.

The medical organization of the system of preventive medicine and public health of New Jersey is described in Chapter Two of this Handbook. At its administrative head is the Sub-Committee on Public Health of the Welfare Committee of The Medical Society of New Jersey, whose members are chosen because of the knowledge and experience which they have gained in the practice of medicine in their local communities. They are the intimate friends of their brother physicians, and understand the methods and plans which are practical and acceptable to their colleagues.

The details of the several branches of the public health activities of the Sub-Committee have been developed by seven Advisory Committees whose members have also had wide experience in local public health work.

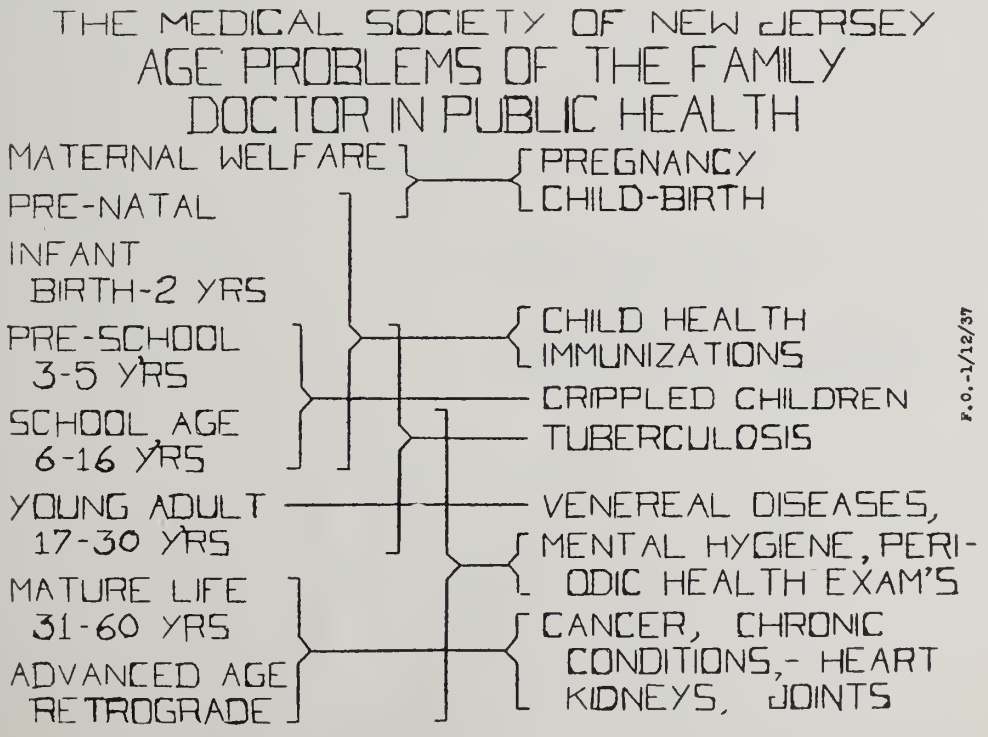


Chart 6.—Health problems peculiar to the age of patients.

The plans of the several committees have been carefully discussed, and full reports of them have been printed in The Journal from time to time. They have also been explained to the county medical societies by the members of the President's Cabinet and others.

The next step in perfecting the New Jersey system of public health practice is that the Family Doctors shall carry out the details of the plans in their private practice of medicine. There is nothing particularly new in the measures that are described and advocated in this Handbook; but rather they are indexes which will help Family Doctors to recall the existing standard procedures when they advise a patient.

AGE GROUPS IN PUBLIC HEALTH WORK

The health problems of every individual are closely associated with his age; and the Family Doctor will be ready to advise every patient, young or old, regarding the problems which are likely to arise during his period of life. (Chart 6.)

Health problems begin with early fetal life, and increase in number and importance to both the fetus and the mother as pregnancy continues. Their seriousness reaches its height during child-birth, when the accident and mortality rates of the child are greater than those of the mother.

The period of infancy is one of adjustment of the baby, tender and inexperienced, to an environment which is strange and hostile. During all this period the mother requires the frequent advice of her Family Doctor.

During the pre-school age the adjustment is well under way, but the child is especially in need of immunizations against contagious diseases.

The years of school life are those of the development of the child physically, mentally, and morally, and the Family Doctor has a grave responsibility for the detection and correction of physical defects, and of mental abnormalities which become evident as the child associates more and more closely with his fellows.

Venereal diseases and tuberculosis are special threats of young adults; and mental disorders are likely to appear in adult life and to require the attention of the Family Doctor.

The Family Doctor will also pay more and more attention to the conditions of organs in full adult life when the body and mind are naturally at the height of their efficiency.

The Family Doctor will watch carefully for cancer during the advanced years of life, and will make prompt use of the means for its diagnosis and treatment.

ADAPTABILITY TO CHANGING NEEDS

The preparation of this Handbook is the first sustained effort by the medical society of any state to enumerate and classify the activities in which general practitioners must engage in order to supply the people of New Jersey with preventive forms of medical service. It has revealed the large number of the ordinary contacts of the Family Doctor and the diversity of the fields in which his authoritative advice is expected. Its adaptability to the varied needs of the several sections of the State will be tested by their physicians, and those features which are found desirable will be incorporated by them as standard forms of medical practice.

The methods of the practice of medicine are not static,—they are dynamic; and the extension of medical knowledge is constantly requiring the assumption of new activities by the Family Doctor. If this Handbook fulfills its expected mission, its own success will in time require a revision of its contents and an extension of the field of information which it covers.

Stanley Nichols, *Chairman*
Theodore Teimer
Julius Levy
Allen G. Ireland
Ernest G. Hummel
I. W. Knight
A. E. Jaffin

CHAPTER FOUR

MATERNAL WELFARE

Arthur W. Bingham, M.D., East Orange, Chairman, Advisory Committee

Periods of Maternal Welfare Practice.
Prenatal,—History Card, Suggested Procedures, Pelvic Examinations, Exercise, Diet, General Directions, Consultations, Field Physician. Literature.
Child-Birth,—Classes of Patients, Assistance, Pamphlet of Instructions, Consultations, Procedures.
Post-Natal,—Follow-up Examinations.

It is well known that the time of pregnancy is the most critical period in the life of a mother; and that the danger of complications increases rapidly as the pregnancy progresses. The danger reaches its maximum at the time of childbirth, and continues in a decreasing degree until the end of the post-natal period. Most conditions of danger to the pregnant woman may be detected readily by the Family Doctor. He has the knowledge and skill to detect abnormal conditions in their incipiency, and to bring both the mother and the child safely throught the pre-natal period, the time of delivery, and the after-care.

The members of The Medical Society of New Jersey have agreed upon a system of maternal welfare which is both simple and comprehensive. The relations of the Family Doctor to the system is shown in chart 7.

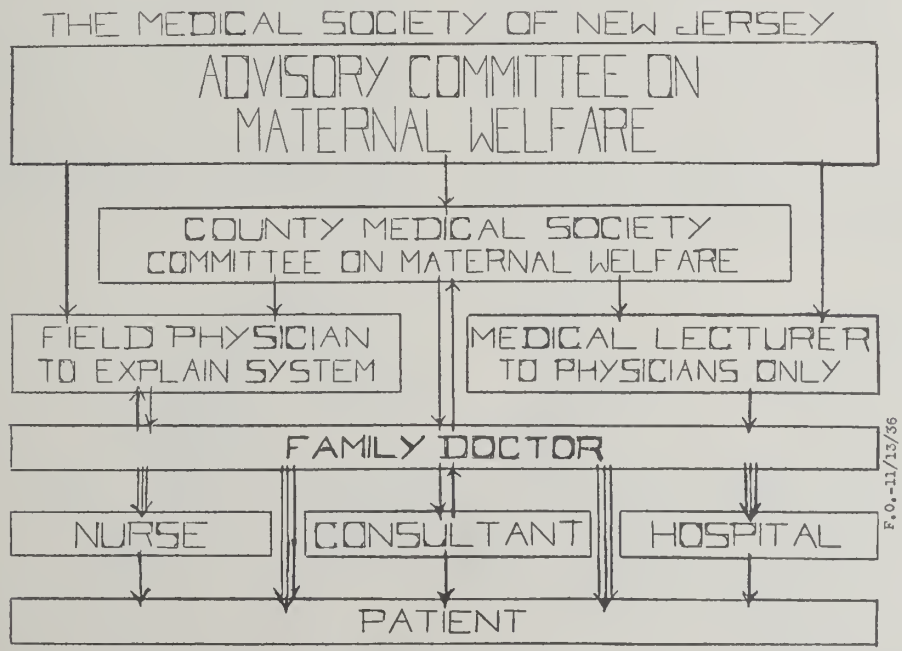


Chart 7.—The relation of the Family Doctor to the Maternal Welfare system of The Medical Society of New Jersey.

The Family Doctor is the center around whom the system of maternal welfare in New Jersey revolves, for he is the medical adviser of the great majority of pregnant women, and attends them at their deliveries and their after-care; but in unusual or difficult cases the system provides the means for assisting him by means of a nurse, or consultant, or a hosiptal. He may also call upon the Committee on Maternal Welfare of the State Society or of his county society for assistance along four lines:

a. A system of lectures on maternal welfare and obstetrics to be given in his home county.

b. The services of a "Field Physician" to advise him regarding the details of the assistance which is offered to him.

c. A consultant of his own choice in difficult labor, toxemia, or other severe conditions.

d. Pamphlets of instruction to be given to mothers, and forms of records of each individual patient.

PERIODS OF MATERNAL WELFARE PRACTICE

The people generally, as well as physicians, have always accepted the principle that every mother is entitled to receive the care of her Family Doctor during child birth; but with the growth of medical knowledge that period has been extended so that it now includes the entire pre-natal period of pregnancy, and extends through the period of post-partum recovery. Family Doctors now recognize that pre-natal and post-partum care is necessary in their obstetrical practice. Many doctors insist that the prospective mothers on their calling list shall come to their office regularly for examination and advice, for the reason that the management of one severe complication involves them in more effort and anxiety than is required to give successful preventive examinations and treatment to several women, to say nothing of the preservation of their professional reputation.

PART 1. THE PRE-NATAL PERIOD

The functions of the Family Doctor to the pregnant woman begin as soon as she suspects herself to be pregnant; and he will continue to advise her until the end of her post-partum period.

FREQUENCY OF PRE-NATAL EXAMINATIONS

The frequency of pre-natal examinations advised by the Maternal Welfare Committee is:

a. Once a month during the first six months of pregnancy.

b. Twice a month during the last three months.

c. On the appearance of any abnormal symptoms.

All these examinations are for the benefit of the child as well as the mother, and may be considered as a part of the child welfare program.

PRENATAL HISTORY CARD

The Family Doctor will need to make a written record of the pregnant mother for two reasons:

1. To refresh his own memory of the procedures at each examination, and to be sure that he considers every important point at every visit of the patient.

2. To impress the mother with his interest in her welfare, encourage her to be persistent in her calls on him.

The Committee on Maternal Welfare of The Medical Society of New Jersey has issued a "Prenatal History Card" for the use of the Family Doctor. The face of the card contains the general information which the Family Doctor should know concerning his patient, and is as follows:

PRENATAL HISTORY CARD

Name..... Address..... Age..... Para.....Grav.
Nature of — Normal — Persistent Vomiting
Previous Pregnancies..... Toxic..... Kidney Disease.....
Nature of — Normal — Instrumental — Caesarian
Previous Labors..... Precipitate..... Prolonged..... Why?.....
Month — Premature Births
Miscarriages..... Curetted..... Stillbirths.....
Last — Probable Date
Menstruation..... Quickening..... of Delivery.....
Distance { Spines — Right Oblique — Ext. Conjugate — Pubic — Normal
between { Crests..... Left Oblique..... True Conjugate..... Arch..... Acute.....
Erect — Inverted — Physical — Heart — Lungs
Nipples Flat.....Exam. Abdomen.....Teeth.....
Operations
Previous Illness .....
.....
Family History .....
Personal History .....
.....
..... Wassermann.....

Issued by the Committee on Maternal Welfare of The Medical Society of New Jersey
Additional copies may be obtained from LeRoy A. Wilkes, M.D., Executive Offices, 137 E. State St., Trenton

The back of the card is for recording the findings at each examination, and is as follows:

Date	Wt.	Blood Pr.	Urine	Toxic Symptoms	Fundus	Cervix	Foetal Heart	Presentation	Notes

Abnormalities .....

Record of Labor ..... Length ..... Instrumental ..... Position of Fetus ..... Hemorrhage ..... Perineum ..... Laceration ..... Cervix .....

Puerperium ..... Normal ..... Fever ..... Convulsions .....

SUGGESTED PROCEDURES IN PRE-NATAL EXAMINATIONS

A Family Physician, called to make a prenatal examination, may have difficulty in recalling every detail of the procedure which he should follow. The following memorandum will enable him to make sure that he has included all the standard procedures that are suggested by the Maternal Welfare Committee of The Medical Society of New Jersey:

1. A history of previous pregnancies and deliveries.

2. A general physical examination.

3. The examination of the urine as to quality and the presence of albumen. Urine should be examined each month up to six months, then every two weeks. Early in pregnancy, it will show acetone and diacetic acid if there is much nausea. Later on, it will show albumen and casts, if there is toxemia. Severe cases may also show acetone and diacetic acid.

4. The weight of the mother, especially any abnormal increase. Excessive gain in weight causes many complications and should be avoided. Patient should be weighed at each visit. During the first three months, as a rule, there is very little gain in weight and very little attention need be given to it. After three months, patients begin to gain, and diet and exercise must be regulated to control it.

The average woman of medium size should not gain more than fifteen or twenty pounds during her pregnancy. Stout patients should gain less, and tall patients may be allowed a few pounds more. The weight should not increase quickly, as a sudden gain will frequently precipitate an attack of toxemia although the total weight may not be excessive. Intake and output of fluids should be checked, especially if there are any signs of toxemia.

5. An estimation of the duration of pregnancy derived from the history given by the patient, and confirmed by external palpation of the abdomen, or a vaginal examination.

6. The detection of abnormal conditions and symptoms suggestive of complications, such as nausea, vomiting, headaches, edema, impairment of vision, desire for abnormal food, and muscular cramps.

7. The blood pressure,—to be taken every month at first, and every two weeks, or oftener if necessary, during the last two months. If blood pressure is high from the beginning of pregnancy, it is probably a case of *hypertension* or *nephritis,* and may not result favorably for the baby.

If blood pressure is normal early in pregnancy and then rises, it is a sign of beginning toxemia and requires active treatment.

If blood pressure is always low, patient may need a tonic or glandular therapy.

8. A hemoglobin test at least three times during pregnancy. This will be found to be lower than under normal conditions. An effort should be made to keep it above 65 per cent.

9. A Wassermann test when syphilis is suspected.

10. A pelvic and abdominal examination.

11. A smear shall be taken of any vaginal discharge.

THE ABDOMINAL AND PELVIC EXAMINATION

In making pelvic and abdominal examinations, the Family Doctor will note the following ocnditions:

1. Whether or not patient is pregnant.
2. Duration of pregnancy.
3. Size of pelvis by taking measurements and thickness of pelvic bones.
4. Presence of tumors, or ecotopic pregnancy.
5. Whether pregnancy is single or multiple.
6. Whether or not fetus is living.
7. Rate and character of fetal heart beats, —after six months.
8. Whether cervix is dilated or closed.
9. Presentation and position of child.
10. Whether to turn or not should be considered, if the presentation is a breech.
11. The size and condition of the fetal head, and whether it is high or low in the pelvis.

A SPECULUM EXAMINATION

A speculum examination should be made early in pregnancy to determine the presence of an erosion, polypus, or cancer.

An erosion should not be treated until six weeks after birth of baby.

A polypus should not be removed until late in pregnancy, unless it is bleeding considerably, for fear of starting up a premature labor.

A cancer of the cervix will probably require a caesarian.

Sterile precautions should be used in making all vaginal examinations, special care being taken during the last month of pregnancy.

EXERCISE

For the first three months very little exercise is needed. There will be less nausea and less danger of an abortion if exercise is limited.

After three months, it is necessary to have the patient exercise in the open air and sunshine, walking one-half to one hour daily.

Many patients tell their Family Doctor they have so much to do about the house that they do not need to walk. This household work does not take the place of a walk in the open; and a short walk should be urged for such patients after the first three months. Walking in the open improves metabolism better than anything else these patients can do; and by improving metabolism there is less toxemia and anemia. Patients in the wards are apt to show more anemia than private patients, partly because they do not always get the right food, but mainly because they are working in the house all day and do not get sufficient exercise in the open air.

Exercise should be regulated, depending on whether the head is high or low in the pelvis, and whether the cervix is thick or thin, dilated or closed.

DIET

For the first three months, starchy foods are best; and if there is much nausea, something should be taken every two hours—one or two crackers between meals is often sufficient.

After three months, starchy foods should be reduced to a minimum, and sweets omitted.

If gaining too much weight in spite of regulation of diet, milk and orange juice given as follows should be tried: Two or three days weekly, in place of regular meals, one glass of milk should be taken with one cracker at 8 a. m., 12 noon, 4 and 8 p. m.; also two or three oranges. A cup of coffee and sometimes one green vegetable may be taken.

On alternate days, a carefully selected general diet may be taken.

When weight is under control, vegetables, salads, etc., may be added to the diet.

During the last two months meat should be reduced, and sometimes omitted entirely for the last four weeks.

CARE OF BREASTS

The Family Doctor will give attention to the breasts of the mother during the latter months of her pregnancy, especially to the following points:

a. Scars, indurations, or other evidences of previous trouble.

b. The nipples, whether sunken, or prominent; the condition of the skin; and the presence of scabs, or cracks.

The Family Doctor will treat the nipples so as to prepare them for nursing when the baby comes.

GENERAL DIRECTIONS

The Family Doctor will also give the pregnant woman advice along the following lines:

1. How to preserve the teeth by careful cleaning, the frequent use of an alkaline mouth wash, and keeping in good general condition.

2. The proper use of calcium and viosterol for two purposes:

a. To prevent muscular cramps in the mother.

b. To insure a proper supply of calcium for the development of the baby. The crown of each front tooth of the first set is fully formed before birth, and still further growth of the tooth consists in a lengthening of its root. The time to begin treating the baby's

teeth is about the sixth month of its intra-uterine life.

3. How much tobacco and alcohol may be used? This should be very limited.

4. How to aid the fetus in settling into the pelvis before labor begins by walking.

5. What to have ready if intending to stay at home; and also what to do, and what to provide, if going to a hospital.

If the mother expects to be confined in her home, she will need the following supplies:

1 pair white stockings.
3 night gowns.
1½ yards square oil cloth or rubber sheeting.
2 lbs. absorbent cotton.
2 lbs. sterilized gauze or equivalent in old, clean linen.
2 hand basins.
1 tube white vaseline.
1 douche or bed pan.
1 large pitcher.
4 oz. bottle lysol.

CONSULTATIONS

Every Family Physician in New Jersey will at all times be consciously aware that instruction, advice, and professional assistance are available to him in every maternal condition of unusual difficulty, so that he will be reasonably assured of his continuance as the adviser of the patient and her family.

The Family Doctor cannot be expected to be an expert in every rare condition which he encounters; but it is for his own interest as well as that of the patient that he shall make use of the consultation service which the Maternal Welfare Committee stands ready to provide for those patients who are unable to pay for it.

FIELD PHYSICIANS

In order that Family Doctors may understand the standard procedures which have been adopted, sixteen field physicians have been appointed to be the *contact* physicians between the Maternal Welfare Committee and the Practicing Physicians in every part of the State.

LITERATURE

A six-page pamphlet, entitled "Minimum Suggested Office Procedures for Pre-natal and Post-natal Care", has been prepared by the Maternal Welfare Committee of The Medical Society of New Jersey. This will be sent free to any Family Doctor who writes for it to the Bureau of Child Hygiene, of the New Jersey Department of Health, Trenton, N. J.

PART 2. PERIOD OF CHILD BIRTH

The patients to whom the Family Doctor is called for confinement may be divided into three classes:

First, those to whom he has given pre-natal advice, including:

a. The mothers who are normal and who have made all the essential arrangements, including a proper outfit, and a nurse.

b. Those in whom some degree of abnormality is present, such as a heart weakness, a small pelvis, toxemia, or a dead foetus. The Family Doctor will advise these patients regarding the special facilities to be provided, including a skilled nurse in attendance.

c. Those who have a serious abnormality requiring expert assistance. The Doctor will make arrangements that those of this class shall be delivered in a hospital, if possible.

Second, those whom the Doctor sees first after labor has begun, and in whom no grave condition is evident.

Third, those to whom he is first called because the mother has been in labor for some time, and a grave emergency has arisen.

ASSISTANCE TO THE FAMILY DOCTOR

The Medical Society of New Jersey has made arrangements by which the Family Doctor may provide needy cases with a trained nurse, or a consultant in emergencies, promptly.

The State Society also coöperates with the county societies in providing lectures on obstetrical procedures for the benefit of Family Doctors.

PAMPHLET ON INSTRUCTIONS

The Maternal Welfare Committee of The Medical Society of New Jersey has prepared the following pamphlet on "Suggestions for Maternity Care During Delivery":

1. In home deliveries be sure there is a competent nurse on the case. If necessary a visiting nurse may be obtained for the delivery.

2. See that there are sufficient supplies on hand.

3. Whether at home or in a hospital, the patient should be prepared before a vaginal examination is made. Vulva and pelvic region should be shaved and scrubbed with soap and water, and then sponged off or irrigated with an antiseptic solution. If there is time, a low soap suds enema should be given.

4. Sterlile gloves should be worn for all examinations and deliveries; hands must be

scrubbed for five minutes before putting on gloves.

5. Gloves should be changed before any repair work is done.

6. Do as few vaginal or rectal examinations as possible.

7. All persons coming in contact with the patient should wear masks during examintions and delivery.

8. Except in post-partum emergency, the doctor should be present when pituitrin is given. If given ante partum, the dose should not exceed five minims, and patient should be ready to deliver.

9. Labor should not be induced except for some urgent complication.

10. Labor should not be hurried, unless condition of patient requires it.

11. Forceps should not be used before the cervix is fully dilated, and the head is well engaged.

12. Take plenty of time for the delivery of the placenta.

13. No douches or intravaginal treatments sholud be given during or after labor.

14. If there are lacerations, time should be taken to make a good repair.

15. Fundus should be held for at least one-half hour after delivery.

16. All circumcisions should be done with strict surgical asepsis. Hands should be scrubbed the same as for any other surgical procedure.

17. Consultation with a competent consultant should be had in all of the following cases:

a. All prolonged labors.
b. Cases requiring cesarean section or induction of labor.
c. Breech presentations (unless very premature).
d. Difficult forceps cases or versions.
e. Occiput posterior presentations requiring forceps or version.
f. Other complicated cases:
   Eclampsia.
   Placenta Praevia, etc.

This pamphlet may be obtained from the Bureau of Child Hygiene of the New Jersey State Department of Health, Trenton, N. J.

PART 3. THE POST-NATAL PERIOD

The suggested medical practice is that the Family Doctor shall attend the mother during her post-natal period, giving special attention to the following points:

Lochia.
The breasts, and nursing.
Diet.
Rest and exercise.
The general condition of the body.
Progress in healing injured parts.

NURSING

The Family Doctor will insist that the baby be put to the breast as soon as the mother has been made comfortable, and every four hours thereafter. This is important for the sake of both the mother and the baby.

For the Mother

a. The act of nursing stimulates the contractions of the uterus and the proper performance of all the functions of the body.

b. Regular nursing periods stimulate the activity of the breasts, and the production of milk.

The Baby. Nursing from the day of birth is also of benefit to the body.

a. The colostrum is valuable as a source of immune bodies, for preparing the digestive tract for milk proteins, and as a source of easily digested proteins.

b. Regular nursing establishes a feeding routine which is essential for the baby's health.

The standard rules for nursing on the days immediately after birth are as follows:

a. Place the baby to the breast within six hours after its birth.

b. For the first twenty-four hours nurse at four-hour intervals, with five-minute feedings on alternate breasts.

c. For the second twenty-four hours nurse at four-hour intervals, with ten-minute nursing.

d. Thereafter nurse for twenty minutes, using the four-hour intervals for infants weighing over seven pounds; and three-hour intervals for those of less weight.

e. Complete emptying the breasts with the breast pump if necessary.

f. Also give some boiled water or a weak solution of sugar, in order to replace the liquid which is naturally given off from the body. Some loss of weight is to be expected until the function of the body are established; but the birth weight will normally be regained in about one week.

THE FOLLOW-UP EXAMINATION

The Family Doctor will invite the mother to return to him for an examination and check-up six weeks after delivery. A memorandum of the procedure to follow is contained in the pamphlet entitled "Minimum Office Procedures". It has the following memoranda regarding the follow-up examination:

At this visit an examination should be made to determine:

1. The general condition of patient (including hemoglobin test).
2. The size and position of uterus.
3. The condition of tubes and ovaries.
4. The condition of perineum and abdominal muscles.

If the uterus is retroflexed, an effort should be made to replace it and to insert a pessary to hold it in position. This may be worn one month, when another examination should be made. A few cases will require a suspension operation. The majority are not inconvenienced by a moderate displacement.

Assuming the knee chest position may be of benefit in restoring the uterus to its proper position. Exercise for strengthening the abdominal muscles may be prescribed.

A relaxed perineum with rectocele and cystocele may require operation at a later date; or a speculum examination should be made to find out the condition of cervix—whether lacerated, eroded, or cystic. Granulations may be found in the vagina. These granulations are to be removed, and the base touched with 20 per cent silver nitrate. If allowed to remain, they will cause considerable discharge.

It is recommended that:

(a) Erosions, small polypi, and cysts be treated with the cautery; also that small lacerations be cauterized, but marked lacerations may require operation.

(b) The patient returns in two weeks to have sloughs removed and astringent used on cervix; but no cautery treatment at this time.

(c) Two weeks later the cautery may be used again, if necessary, and the patient told to return after a month. At this visit it is probable that the cervix will be healed.

It is advisable for all patients to return for a final check-up six months after delivery.

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CHAPTER FIVE

CHILD HEALTH

STANLEY NICHOLS, M.D., Asbury Park, Chairman, Sub-Committee on Public Health

Relations of Family Doctor
Periods of Child Life
Prenatal Care
Birth and Post-natal Weeks
Infancy and Development
Baby Keep-Well Stations
Pre-school Age
School Age
Physical Examination Form
Immunization
Tuberculosis

Babies and children always arouse attention and sympathy; and there are more agencies for their benefit than for the welfare of any other age group. The Family Doctor comes next to the mother in caring for infants, but many other agencies also offer their services. The relations of the Family Doctor to these agencies are shown in Chart 8.

The Family Doctor is the medical adviser of the baby as well as its mother. He directs the services which the mother, the nurse, or the dietitian gives to the baby. Standards of the services of the methods of their delivery to the child home-born have been developed by The Medical Society of New Jersey and transmitted to the Family Doctor through the County Medical Society.

A great number of agencies—local, State

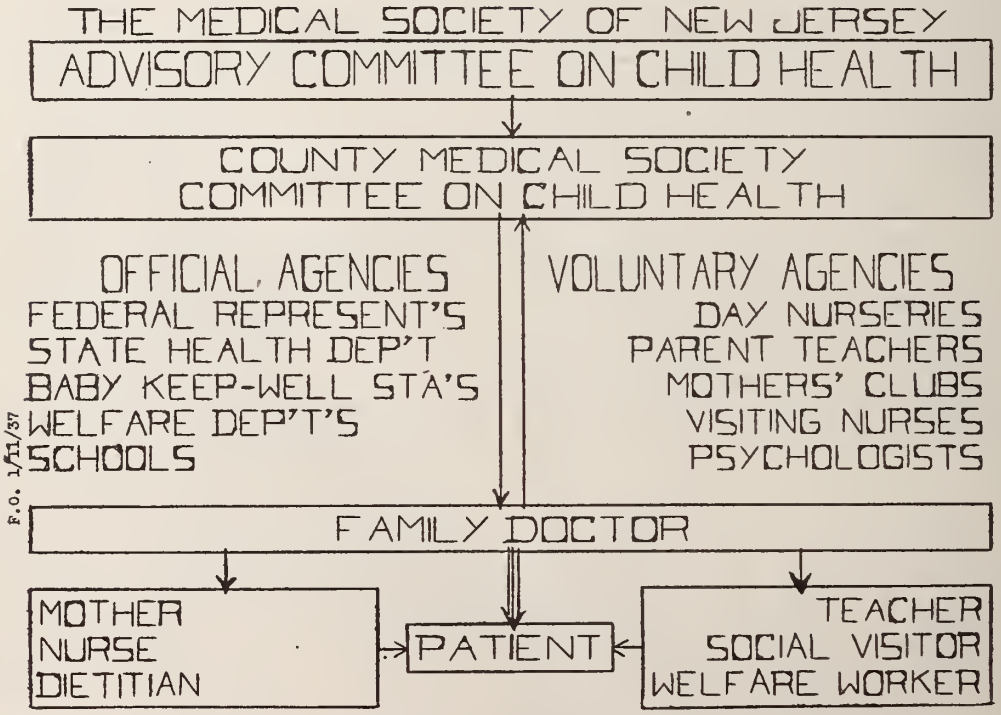


Chart 8.—The relations of the Family Doctor to other agencies in child health service.

and national, and both official and voluntary—offer advice, and social visitors or welfare workers are ready to deliver the services of health agencies; but their relations to physicians are not always clearly defined. However this freedom of choice permits the Family Doctor to secure their assistance with a minimum of formality.

PERIODS OF CHILD LIFE

The activities of the Family Doctor in child health are concerned with five distinct periods of a child's life:

1. Prenatal.
2. The period of its birth.
3. Infancy, from birth, through two years.
4. The pre-school age, from the third through the fifth year.
5. The school age, six to seventeen years.

1. PRENATAL CARE

The Family Doctor gives essential medical service to an unborn child by treating the mother throughout the months of her pregnancy. Anything which benefits the mother also promotes the health of the unborn child. (See chapter on Maternal Welfare, page—.)

However, the Family Doctor is expected to give direct service to the infant in utero, by advising the mother along the following lines:

a. Give the mother calcium and viosterol for promoting the formation of enamel on the baby's growing teeth. (See page——.)

b. Treat her breasts and nipples in preparation for nursing the baby when it comes.

c. Treat the mother for diseases which may infect the child, such as syphilis and tuberculosis.

d. Give advice to the mother regarding the dress and toilet articles to have ready for the new-born infant. The following list of necessary items is given in the pamphlet, *"Suggestions to the Expectant Mother"*, which is distributed free by the Bureau of Child Hygiene of New Jersey State Department of Health, Trenton, N. J.:

2 light-weight woolen blankets.
1 old blanket.
3 cotton and wool undershirts.
3 flannel shirts.
3 outing flannel gowns.
4 cotton slips.
3 straight bands.
3 knitted bands with shoulder straps.
3 dozen diapers.
1 box boric acid.
1 box talcum powder.
1 piece castile soap.
¼ lb. sterilized gauze.
¼ lb. sterilized absorbent cotton.
2 dozen safety pins, large and small.

Insist that these articles are actually on hand, and not leave that duty entirely to the nurse. A friendly interest in the baby will promote the confidence of the mother in her doctor.

2. BIRTH AND THE POST-NATAL WEEK

Birth Injuries. A Family Doctor will consider the welfare of the forth-coming baby to be equal to that of the mother. (See chapter on Maternal Welfare, page 19.) While he will act promptly in an emergency, he will avoid unnecessary haste in the delivery of the child. Injuring the brain and nerves is likely to result from the rapid extraction of the child, or the forcible compression of the head with forceps. The skull and brain will safely undergo a considerable amount of molding if it is done gradually and by the intermittent action of the muscles of the mother's abdomen and pelvis.

Asphyxia. Failure of the new-born baby to breathe is often the result of pressure from an intra-cranial hermorrhage which will be increased by forcible attempts to do artificial respiration. In these babies the indication is to do a spinal puncture in order to remove the blood which is compressing the brain.

The New-born Baby. The Family Doctor will see that the new-born baby receives immediate attention along the following lines:

a. Applying a drop of a one per cent solution of silver nitrate to each eye as a preventive of ophthalmia neonatorum.

b. Dressing the cord and umbilicus.

c. Inspecting the baby for malformations and defects.

d. Seeing that the baby is properly washed and dressed, and that its bed and room are suitable and hygienic.

Post-Natal Calls. When the doctor makes his regular post-partum calls on the mother, he will give particular attention to the infant also, especially along the following lines:

a. The condition of its navel. Use the straight abdominal band until the navel is headed; then change to a loose band with shoulder straps.

b. Its nourishment, especially giving bottled water until its nursing or feeding schedule is established.

c. Its loss or gain in weight. There is a natural loss of weight during the first day or two because of the excess of the excretions

over the intake of food and drink; but the doctor will guard against the baby becoming dehydrated.

d. The infant's skin and excretions.

e. The cleanliness of its mouth.

3. PERIOD OF INFANCY

After the family doctor has completed his series of post-natal calls on the mother, the baby will require his attention about once a month during its first year; and once every three months during its second year. The object of the visits is to direct the routine of the baby's life so that it will remain healthy and will grow and develop normally.

BREAST OR BOTTLE FEEDING

Almost the first question which the doctor will be asked to decide is the choice between breast and bottle feeding. The rates for both sickness and deaths among bottle-fed babies is higher than among the breast-fed.

The Family Doctor will insist on a continuance of breast feeding, but will be prepared to advise a formula for artificial feeding if necessary.

The amount of food which a bottle-fed baby requires is as follows:—

At each feeding, give one and half ounces of milk for each pound of the child's weight.

During the day, give one ounce of carbohydrate (cane sugar, lactose, dextrose, or other form of sugar).

This diet will supply about one and a half grains of protein per pound of body weight, and about 40 or 50 calories.

Both breast-fed and bottle-fed babies need to be assured of a supply of the vitamins which are contained in fruit juices and cod liver oil. It is the function of the Family Doctor to advise the mother in an adequate choice from among the preparations that are available—some expensive and some at low price. His advise is especially essential when the baby is fed on any preparation of canned milk.

DEVELOPMENT OF THE BABY

The Family Doctor is the proper judge of the development of the baby's growth, both physically and mentally. A chart of these developments at various months has been approved by the New Jersey Section of the American Academy of Pediatrics and will be sent free by the bureau of Child Hygiene of the New Jersey State Department of Health. Every Family Doctor is urged to secure one of the charts; and to frame and display it in his office where both he and the mothers may consult it readily. Displaying it prominently and showing the mother how to use it will assure the mother that the doctor is keenly interested in her baby's welfare, and is fully informed regarding the procedures which are necessary or desirable.

GROWTH

Age	Pounds	Inches
Birth	7	20
1 Mo.	9	22
3 Mos.	12	23
6 Mos.	16	25
9 Mos.	17	27
12 Mos.	20	29
18 Mos.	22	30
2 Years	26	32

Average Gain

First 6 months: 6 to 8 ounces per week.
Second 6 months: 4 to 6 ounces per week.
Second Year: 3 ounces per week.

SIGHT, HEARING AND SPEECH

Age	*Sight*	*Hearing*	*Speech*
Birth	Avoids light during first weeks	Acute at end of first week	
1 M.	Eyes Cross	Easily disturbed	
3 M.	Eyes coördinate	Turns head toward sounds	
6 M.	Objects and familiar people recognized	Recognizes familiar voices and sounds	Coos
12 M.			Utters words
18 M.			Connects words

SUMMARY—PHYSICAL AND MENTAL DEVELOPMENT

2 months: Posterior fontanel closed; tears.
3 months: Drooling; holds head erect.
6 months: Notices objects; handles toys; recognizes family.
9 months: Sits alone; first tooth.
12 months: Stands alone; talks; six teeth.
14 months: Walks.
18 months: Anterior fontanel closed; twelve teeth.
2 years: Twenty teeth.

PERMANENT TEETH

1st Molars	6 yrs.
Incisors	7-8 yrs.
Bicuspids	9-10 yrs.
Canine	12-14 yrs.
2nd Molars	12-15 yrs.
3rd Molars	17-25 yrs.

MISCELLANEOUS INFORMATION

Lachrymal gland—usually active about 2nd month.
Sweat gland—usually active about 3rd or 4th week.
Salivary gland—not fully active until about 3rd or 4th month.

THE BABY'S DEVELOPMENT, NUTRITION AND ACTIONS

Condensed from the large chart

BODY DEVELOPMENT				HABITS		DANGER SIGNALS	FOR DIAGNOSIS CONSIDER
AGE	NEURO-MUSCULAR	HEAD	TEETH	FOOD	SLEEP		
Birth	Cries lustily	Anterior and Posterior Fontanels open	Crowns of first set formed. Four of permanent set partly formed	Breast milk 3- to 4-hour intervals. Ten- to 20-minute nursings	Ventilated, darkened room. About 22 hours per day	Very quiet, does not cry, does not take breast.	Birth Injury? Cerebral Hemorrhage?
						Rising temperature and losing weight.	Sepsis? Insufficient fluids?
1 Mo.				½ teaspoon cod-liver oil 3 times a day Sept. to May. ½ teaspoon once a day May to Sept. Orange juice		Atrophy, snuffles.	Syphilis?
						Severe protracted vomiting on breast	Pylorospasm? Hypertrophic Pyloric Stenosis?
3 Mos.	Plays peek-a-boo. Lifts head	About two months Posterior Fontanel closes	Salivary glands active. Drooling.	Relief bottle	About 20 to 22 hours per day	Failure to gain Apathetic—no appetite	Inadequate nursing? Incipient Rickets? Hypothyroid?
6 Mos.	Handles toys. Attempts to sit up		6 to 8 months 1 tooth	Cereal—1 to 3 tablespoons	About 18 to 20 hours per day. 6 p. m. to 6 a. m.	Gaining slowly, development delayed	Rickets?
						Cries on handling	Scurvy?
9 Mos.	Sits up. Raises self to feet		2 teeth	Start to wean. Egg yolk, strained vegetables or soup	18 hours per day 6 p. m. to 6 a. m.	Convulsions	Rickets?
						Attacks of vomiting, crying, bloody stools	Intussusception?
12 Mos.	Stands alone. Takes few steps	14 to 22 months Anterior Fontanel closes	6 teeth	Stewed fruit, baked potato, plain milk puddings, jello	6 p. m. to 6 a. m. Daily nap	Flabby, very good. does not sit up. Anterior fontanel not closing	Mental defect? Rickets?
						Hoarseness with slight fever.	Diphtheria?
18 Mos.	Walks freely		12 teeth	Broiled scraped beef. minced lamb or chicken	6 p. m. to 6 a. m. Daily nap	Deep, rapid breathing during acute illness	Acidosis?
2 Years			20 teeth	All simple foods—Heavy meal in the middle of day	6 p. m. to 6 a. m. Daily nap	High fever with no symptoms	Pyelitis? Otitis?

Prepared and distributed by the Bureau of Child Hygiene, New Jersey State Department of Health, from whom the entire chart may be obtained by any physician.

Endorsed by the Child Health Committee of The Medical Society of New Jersey.

DIAGNOSTIC HINTS

Rickets

Startles, perspires, "holds breath".
Delayed development and failure to gain.
"Rosary" cranio-tabes, thickened wrists.

Scurvy

8 to 12 months. Cries on handling.
Swelling of thigh—(No inflammation).
Well nourished. Spongy gums (bluish).
Cured in 3 days on orange juice.

ROUTINE SUPERVISION

A pamphlet entitled "Routine Supervision of Young Infants" has been prepared by Dr. Julius Levy, Director of the Bureau of Maternal and Child Hygiene, and approved by the Committee on Child Health of the Medical Society of New Jersey, and will be sent free to physicians applying to the Bureau of Child Hygiene of the New Jersey State Department of Health. The pamphlet is as follows:

Purpose—To educate mothers:

a. In the proper care, feeding and management of infants.
b. To understand normal growth and development.
c. To prevent contagious disease by "conscience quarantine".

Examination of Infants:

Due to the high mortality in the first weeks of life, it is desirable that infants should be carefully examined and watched during this period. It is recommended that infants be examined monthly during the first year, three to four times during the second year, and twice a year thereafter:

a. To observe growth and development, mental as well as physical.

b. To regulate feeding.

c. To prevent nutritional and deficiency disorders, such as rickets and scurvy.

Orange juice and cod-liver oil should be given to infants after one month of age. It is particularly important to give approximately one and one-half teaspoonfuls of standardized cod-liver oil by the end of the second month during the winter. During the summer months exposure of the skin directly to sunlight may replace cod-liver oil.

d. To arrange for protection against certain diseases through vaccination before six months of age and immunization before one year of age; and for the application of other protective measures as experience justifies, such as those against scarlet fever and whooping cough.

e. Detection of defects and deformities.

For these purposes physicians should have a knowledge of simple methods of feeding; of average standards of growth and development; of general hygiene; and of accepted practices in the prevention of disease.

The following equipment is necessary:

1. Scales.
2. Records.
3. Hypodermic syringe.
4. Materials for vaccination and immunization.

Pre-school children should receive a routine examination at least twice a year to determine normal growth and development and the existence of any defects or deformities.

The physician has an unusual opportunity to help the mother in principles of training as well as of physical management. A knowledge of simple parent-child relationships, so as to guide mothers in behavior problems, or rather the prevention of such problems, is very desirable.

BABY KEEP-WELL STATIONS

A great value of the system of *Baby Keep-Well Stations,* which are planned under the joint auspices of the State Department of Health and the County Medical Societies, is the opportunities which they afford family doctors to observe the methods of examining babies and judging of their conditions and needs. A couple of hours observation of a dozen babies in an afternoon will be an inspiration and incentive to the family doctor to spend an evening reading about the conditions which he has observed, and the treatments which are indicated. Every Baby Keep-Well Station is a potential center of post-graduate clinical study which is available to every family doctor.

The decision regarding the admission of a child to a station rests with the physician, who may use the report of the station nurse regarding conditions in the home of the mother.

The principles on which Baby Keep-Well Stations are conducted are shown in the following circular of information issued by the Bureau of Maternal and Child Health of the New Jersey Department of Health.

PURPOSE OF BABY KEEP-WELL STATION

The Baby Keep-Well Station should be used primarily as a teaching center. Here nurses and mothers should learn from the doctor:

First, the importance of watching the growth and development of the well baby,—not the purpose of discovering any pathological condition but to impress the mother with the importance of regular examination by physician.

Second, that through proper management and feeding, infants can be kept well and normal.

Third, that by careful examination, it is possible to detect very early signs of delayed development or incipient rickets, scurvy and other deficiency diseases.

It is desirable at the Baby Station to examine infants and advise parents at least once a month. The attention of the mother should be called to any evidences of improper care or management. Inquiry should be made as to the method and frequency of feeding. The purpose of these teaching centers is not merely to see that the infants progress satisfactorily; but also to have mothers understand thoroughly normal growth and development and the reasons for the recommended methods in the care of the infant.

Emphasis should be placed upon the value and importance of:

Maternal nursing.

Regularity in feeding and management.

Great importance of sunlight and fresh air.

Protection against deficiency diseases by the use of orange juice and cod-liver oil.

Protection against certain diseases by immunization and vaccination.

The Baby Keep-Well Station should be considered merely one part of the child hygiene program for educating mothers in the proper care of infants. It should never be called a clinic, for it is essentially a teaching center.

Sick children are not to be treated at the Baby Keep-Well Station. Mothers should be instructed not to bring any infants or children with even slight disturbances, such as fever, coughs or skin troubles, to the Baby Keep-Well Stations. The Baby Station is purely an educational center for keeping well babies well. Mothers who can afford to pay for this kind of service should be urged to take their infants to their private physician.

4. THE PRE-SCHOOL AGE

The pre-school age—from three to six years—is probably the most neglected period of the life of every person. These are the years when children are popularly supposed to "Outgrow" their weaknesses, and their tendencies to ill health; and parents are prone to neglect the conditions, unless their attention is called to them for their Family Doctors.

The Family Doctor is in a peculiarly favorable situation to inform the parents of the conditions of their children, and to suggest the means of their corrections.

IMMUNIZATIONS

The great danger to which children of the pre-school age are exposed is that of communicable diseases—the so-called childhood diseases.

This is the age period when every child is entitled to protection against communicable diseases, especially diphtheria and smallpox. The *Public Health Hour* was planned with the expectation that the office of every family doctor should be a "Health Center" where immunizations are given at prices which the parents can afford to pay. Experience over a period of two years has shown that physicians are ready to coöperate in the plan, but that parents do not readily respond to the invitations to bring their children to the office of their Family Doctor. The essential element that is lacking is "Popular Education" in order that the people shall realize the importance and necessity of having their children immunized.

The family doctor can render essential services in promoting popular education regarding immunizations by taking the following steps:

1. Inviting parents to bring their children to their offices for the immunizations. It is no longer considered "Unethical" that family doctors solicit the coöperation of parents, for this has been unanimously approved and urged by The Medical Society of New Jersey.

2. Taking advantage of every opportunity to explain the subject of immunizations to their own friends and acquaintances. These casual talks will have a great effect in arousing the people to bring their children for the immunizations.

3. Promoting talks on the subject to be given to organizations of a civic, social, and fraternal nature. The people will respond when they realize the necessity of securing the immunizations.

CORRECTION OF DEFECTS

The physician who is in fact the "Family Doctor" of a household, usually knows of children's defects in their incipiency before the parents themselves are aware of their existence; and understands their threats to the health, happiness, and usefulness of the children if they are neglected. He will inform the parents of those defects and will suggest the means of their correction, particularly those of the eyes, ears, teeth, and feet.

In the prevention or correction of defects, as well as in immunizations, measures of "Popular education" are essential. An aroused and enlightened public opinion under the leadership of Family Doctors is necessary in order to popularize measures for correcting the defects in their early stages.

The support of the Family Doctor is essential in arousing parents to aid in correcting these defects of the pre-school child.

5. THE SCHOOL AGE

After the child enters school, the Family Doctor continues as his health adviser, with two advantages:

1. The law requires that every school child shall undergo a physical examination.

2. Defects which the parents overlook, or suppose the child will "outgrow", stand out when the child joins a class in which he must compete with other children in appearance, behavior, athletics, and scholarship.

The Family Doctor often finds the parents receptive to advice to which they were indifferent before the child went to school; and he therefore has an increased responsibility for the maintenance of the child's health.

THE PHYSICAL EXAMINATION

The experience of the operation of the compulsory examination of school children has shown which examinations are useful, and which ones are too refined and difficult for ordinary application. The Family Doctor will find an excellent guide to be the standard form issued by the Division of Physical Health and Education, of the New Jersey State Department of Public Instruction, of which Dr. Allen G. Ireland, Trenton, N. J., is Director. The essentials of this form are as follows:

A. VISION: Findings .....
.....Has glasses; .....Should wear glasses for close eyework at school.
.....Seat at front of room; .....middle;
.....near window.
.....Rest eyes frequently; .....Avoid long-continued reading. .....Avoid fine print;
.....Give attention to light. .....Needs advice.
B. HEARING: Findings .....
..... Seat at front of room; .....middle.
.....Needs advice.
C. TEETH: Findings .....
.....Under dentist's care; .....Has been reported to dentist.
D. NUTRITION: Findings .....
Height and weight ..... normal.
..... under normal.
..... Needs mid-day lunch.
..... Needs rest period.
E. NOSE AND THROAT: Findings .....
.....Mouth breather. .....Tonsils.
.....Colds or "Sniffles".
F. HEART: Findings .....
..... Can engage in normal sports.
... . Special precautions.
G. LUNGS: Findings .....
..... Asthma; .....Tuberculosis.
H. SKIN: Findings .....
... Color. ... Abnormalities and diseases.
I. SKELETON: Findings .....
..... Posture. .....Defects.
..... Need of orthopedic advice.
. . Need of corrective exercises.
J. Emotional Disturbances and Mental Disorders.

COMMUNICABLE DISEASES

The family doctor will be deeply concerned with communicable diseases among the children for whose health he has a special responsibility.

1. He will insist on giving immunizations, especially against diphtheria and smallpox, rather than leaving that duty to the school physician and the clinic.

2. He will advise the parents to keep the child at home *and isolated from other children,* on the appearance of signs which are suggestive of a communicable disease. He will do this for two reasons:

a. The benefit of the child itself, so that he is not exposed to the ordinary dangers of doing as he pleases.

b. The protection of other children with whom he is sure to come in contact at school.

Closing School. The Family Doctor will take an active interest in the proposition to close the school on the appearance of a few cases of sore throat, measles, whooping cough, scarlet fever, or other highly contagious diseases. In ordinary conditions he will advise that the school be kept open (see p. 63).

IMMUNIZATION CLINICS

Every Family Doctor is deeply interested in the question whether or not the school shall conduct immunization clinics.

The ideal system would involve the coöperation of the teachers, the parents, and the Family Doctor, according to the following system:

a. A note to the parents requesting them to take the child *to their Family Doctor* for the immunization.

b. A check-up to see if the child has been immunized.

c. Sending the visiting nurse to the home in order to urge the parents to call on their Family Doctor for the immunizations. She will discover the reasons that the parents give for their negligence, among the more common ones being:

1. Have no Family Doctor.
2. Owe the doctor for previous calls.
3. Don't believe in the immunizations.

The Family Doctor is the key man in securing the immunizations. He can promote the plan by taking the following steps:

a. Support the plan by word and action.

b. Join with his fellow practitioners in devising a practical plan of coöperation between themselves, the school authorities, and the voluntary health agencies, especially along economic and educational lines.

c. If a clinic becomes necessary in order to secure the immunizations, let the Family Doctor insist on the appointment of a committee who shall plan and conduct the clinic in accordance with the principles of the County Medical Society.

TUBERCULOSIS

Valuable statistics show that the group among which tuberculosis is most prevalent is that of school children in the "teen" ages. Physicians are agreed that the most practical and effective method of detecting cases of tuberculosis is that which involves the examination of every school child in the teen age by the following steps:

a. A tuberculin test.

b. An x-ray of the chests in the positive reactor.

c. The special treatment of those who are found to have the disease.

The Family Doctor is the key man in carrying out the plan. He can promote it by taking the following steps:

a. Support it actively by word and deed.

b. Join with his fellow practitioners in planning a satisfactory method of making the examinations in his own community, and presenting the plan to the school and welfare authorities.

c. Standing ready to carry out the treatments which may be required; and to perform his duty as a Family Doctor to the parents of those who have tuberculosis.

Stanley Nichols, *Chairman*
Ernest G. Hummel
Walter B. Stewart
L. Charles Rosenberg
Victor A. Blenkle

CHAPTER SIX

CRIPPLED CHILDREN

ELMER P. WEIGEL, M.D., Plainfield, Chairman, Advisory Committee

Organs of Voluntary Motion.
A Complete Orthopedic Service.
Recognition of Family Doctor.
Chart of Relations of the Family Doctor.
Poliomyelitis,—Stages, Civic Organizations.
Tuberculosis of Bones and Joints.
Traumatisms.
Burns.

Crippled children are those who either because of birth defects or as a result of disease or injury, are rendered incapable of full normal use of some part of their body, especially the system for voluntary motion.

ORGANS OF VOLUNTARY MOTION

The organs of voluntary motion may be divided into two groups:

1. The bones, joints, and voluntary muscles.
2. The nervous system which originates, directs, and controls those movements.

Serious crippling is often the result of injury or disease of the bones, joints, or muscles, while the nervous system is intact. But if the primary defect is in the nervous system, as in poliomyelitis, secondary defects occur in the muscles, such as contractures or excessive relaxations or degenerations; and these in turn are followed by changes in the bones and joints.

The intricate system of organs of voluntary motion of the human body may be compared with the rigging of a full-rigged ship, which consists of an intricate system of spars (bones), ropes (tendons), and pulleys (joints), together with manpower, or engines (muscles), for producing the movements. To these are added the trained officers and seamen (nervous system), who direct and control the movements of the ropes, sails and rudder.

When any part of the ship's rigging is seriously deranged, its recognition and repair require the services of expert riggers (orthopedists), who can recognize the source of the defect, and reconstruct the defective part from materials which are on board the ship (from other tissues).

The number of organs of voluntary motion of the human body are listed about as follows:

Bones	225
Joints	150
Muscles	200
	575

The study of the functions of these structures by the Family Doctor seldom extends beyond the first year of the medical school, except a brief course in orthopedics in which the student seldom has time for little more than a review of his first year anatomy. But the responsibility for recognizing and securing the correction of orthopedic defects frequently comes to the Family Doctor, since he is often confronted with cases of these conditions in the families of which he is the medical adviser.

A COMPLETE ORTHOPEDIC SERVICE

The Medical Society of New Jersey is organizing a system of orthopedic service for the benefit of the Family Doctor as well as the patients. The system involves the coöperation of a number of agencies, as follows: (See chart 9.)

1. The Advisory Committee on the Care of the Crippled Children.
2. A similar committee in each county society.
3. An orthopedic service in a sufficient number of hospitals to enable the Family Doctor to secure the diagnosis and treatment of every crippled child on his calling list, regardless of the financial status, or social rank of the families of the patients.
4. Provision for instructing every Family Doctor who refers a case to the hospital or consultant.
5. Provision on the programs of county

societies for demonstrating cases, and the methods of diagnosis and treatment suitable to each case.

6. The establishment of a system of visiting nurses skilled in giving muscular training, massage, and other manipulations, under the direction of the consulting orthopedist, and the Family Doctor.

7. The coöperation of welfare agencies and social organizations in providing hospitalization, and apparatus for every needy case.

8. Providing facilities for the education and recreation of the afflicted children, so that the children may engage in activities which approach those of normal children.

The successful results of these services have been demonstrated so frequently that three obligations rest upon every Family Doctor:

1. To secure these services for every crippled child on his calling list.

2. To follow up every case which he refers to a hospital or consultant; and to review its history, its diagnosis, and the principles of its treatment.

3. To encourage the patient and the members of the family to persist in the acceptance of the service, and in doing their part in carrying out the treatment.

RECOGNITION OF THE FAMILY PHYSICIAN

Two further procedures are necessary in order to insure success in the State-wide system which has been devised:

1. That every patient treated in a hospital or clinic shall be required to name some physician as his Family Doctor to whom periodic reports of the case shall be sent.

2. That every Family Doctor named as the medical adviser of a case shall accept his responsibility, and shall in turn make reports to the hospital or consultant regarding the progress of the case, and the attitude of the family.

These two requirements are necessary for two reasons:

1. To prevent the patient falling into the hands of cultists who make impossible promises of cures by their system.

2. To enable the Family Doctor to become familiar with the fundamentals of the diagnosis and treatment of these conditions.

THE RELATIONS OF THE FAMILY DOCTOR

The relations of the Family Doctor to crippled children and to other organizations are shown in the following chart:

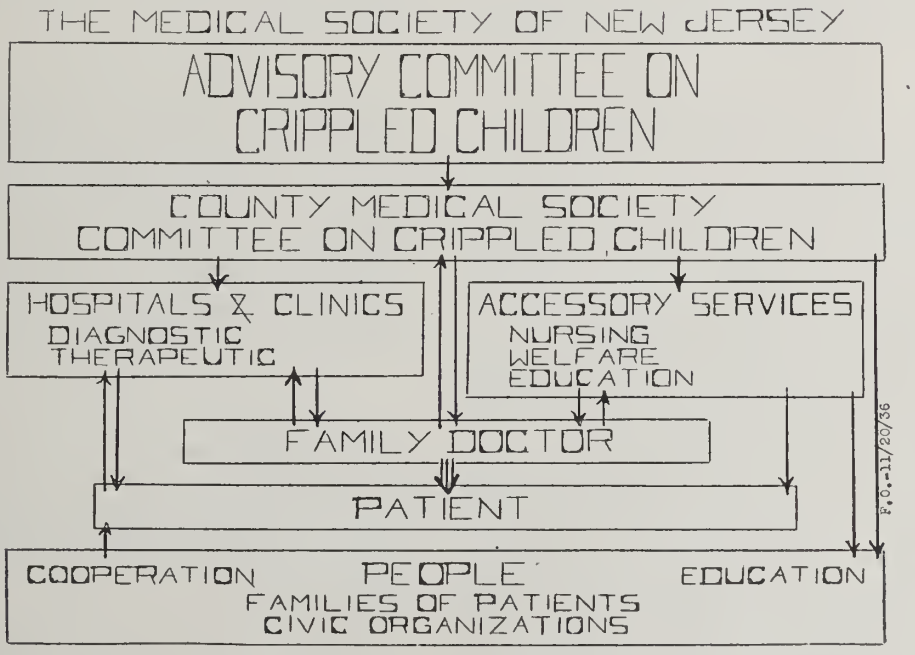


Chart 9.—The relation of the Family Doctor to other health agencies that give service to crippled children.

The Family Doctor is the center around whom the services of The Medical Society of New Jersey revolve.

He will either deliver the services himself, or to refer the patient to an orthopedist or a hospital or clinic which is approved by the Committee on Crippled Children of the Welfare Committee of The Medical Society of New Jersey.

The Family Doctor will make every effort to be present at the hospital or clinic to which he refers his patient; and to confer with the consultant who makes the examination or performs the necessary operation.

He will make every effort to understand the pathology of the defects, and the measures which are necessary for their correction.

He will supervise the exercises and other treatments which are prescribed by the consultant; and shall make reports to the consultant, or cause them to be made by the visiting nurse or muscle trainer who is assigned to the patient.

He will put forth every effort to encourage the patient and the members of the family to persist in the treatment.

POLIOMYELITIS

Poliomyelitis is one of the most frequent causes of the crippling of children. The treatment of these patients will be in three stages:

1. The Acute Stage

The acute stage of poliomyelitis usually lasts from six to eight weeks. It is important that the Family Doctor secures the services of a consulting orthopedist *early in the disease* in order to make an accurate estimate of the conditions which are present or may be anticipated.

In general, the treatment in the acute stage will consist of the following measures:

a. Rest of the affected parts, and keeping them in a position which will prevent contractures of the normal muscles, and secondary changes in the joints and ligaments.

Inasmuch as exercise and massage are harmful in the acute stage, the Family Doctor will be on guard against masseurs and muscle trainers with whom these harmful procedures are the only forms of treatment. It is therefore suggested that the Family Doctor call an orthopedist into consultation frequently, in order to reassure the parents and encourage them to persist in carrying out the measures which are prescribed for ensuring rest of the affected parts during the acute stage of the disease.

b. External application of moderate heat by warm bathing usually adds to the patient's comfort in this stage.

2. The Sub-acute Stage

After the acute stage of the disease has passed and fever and soreness have subsided, the Family Doctor will begin to exercise the affected parts,—first by passive movements, and then by encouraging the patient to undertake the movements with his own muscles. These movements must be begun gently and gradually, and under the explicit direction of the orthopedist.

3. The Chronic Stage

During the chronic stage three measures must be considered, as prescribed by the consulting orthopedist:

a. The continuance of the graded exercises.

b. The application of proper braces.

c. Operations for transplanting muscles and tendons, or of joint fixation; followed by re-education of the patient in the use of his newly applied muscles and stiffened joints.

The results of these methods of treatment are often very satisfactory, and in many cases a seriously crippled child may reasonably expect to be able to perform a fair degree of normal movements.

KINDLY INTEREST

Success of the treatment of children crippled with poliomyelitis will depend largely upon the kindly interest of the Family Doctor, whose every visit is an inspiration, and a joy to be anticipated by the patient and his parents.

Little acts of kindness by the Family Doctor, and friendly attention are important in maintaining the confidence of the child and his parents in his scientific treatment.

CONTACTS WITH CIVIC ORGANIZATIONS

Every crippled child is of special interest to civic organizations such as Elks and Service Clubs. The leaders of these organizations will welcome the suggestions of the Family Doctor, and will coöperate with him in providing the assistance which he may require.

TUBERCULOSIS OF BONES AND JOINTS

Next to poliomyelitis, tuberculosis of the bones and joints are probably the most common causes of the crippling of children. Here the same principles of coöperation with orthopedists and civic organizations are necessary.

TRAUMATIC SURGERY

The Family Doctor may also utilize the services of the system of The Medical Society of New Jersey in handling difficult cases of fractures, burns, and other crippling injuries. In all these injuries, treatment by an orthopedist in a well-equipped hospital is usually necessary; but the proper after-care in the home requires the same expert supervision as that of a case of poliomyelitis.

BURNS

Severe burns are likely to be followed by an excessive production of scar tissue and contractures. Preventing these contractures usually requires the services of an orthopedist.

The Family Doctors of New Jersey are fortunate in being an essential part of the system of services provided by The Medical Society of New Jersey for the prevention and treatment of crippling conditions of children. But these services are available to persons of any age,—adults as well as children. The Committee on Crippled Children is so named simply because the great majority of cases are among children.

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F. G. DILGER
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CHAPTER SEVEN

TUBERCULOSIS

B. S. POLLAK, M.D., Jersey City, Chairman, Advisory Committee

Popular Attitude Toward Tuberculosis.
Public Relations of the Family Doctor.
The County Medical Society.
Anti-Tuberculosis Organizations.
Reporting Cases.
Discovering the Source of Infection.
Diagnostic Procedures,—Case History, Physical Examination, X-Ray, Sputum, Tuberculin.
Tuberculosis in the Teen Ages.
Stages of Tuberculosis.
Preventive Advice.
Hospitals. List of Institutions.
Diagnostic Clinics.
Treatment of Tuberculosis,—Hygienic, Medical, Surgical.
Educating the People.

Although tuberculosis has been cut to one-half or one-third of its prevalence two decades ago, it still remains one of the most common diseases in New Jersey as elsewhere in the United States. Physicians know the nature of the disease and the means of controlling it; but there is a great lag in the application of the preventive and curative measures because administrative and social methods have not kept pace with scientific knowledge.

Tuberculosis may affect any organ of the body; but this chapter deals specifically with *tuberculosis of the lungs.*

THE POPULAR ATTITUDE TOWARD TUBERCULOSIS

Among the peculiar conditions which prevent tuberculosis patients from carrying out the diagnostic and therapeutic measures prescribed by the Family Physician are the following:

a. The popular fear of the disease, leading patients to delay consulting the doctor lest he should diagnose the condition as tuberculosis, —which to many people still brings to mind the old picture of "consumption".

b. The popular ignorance of the infectious, contagious, and communicable nature of the disease, leading to luke-warmness of the patients and their families in following the doctor's directions.

c. The usual slow, insidious onset of the disease, and the resemblance of its symptoms to those of non-tuberculous conditions, thereby misleading the patients and their families into acting upon a false presumption that is in line with their own desires.

d. The strong inclination of patients to revert to their former habits of living as soon as improvement is evident, and before a safe degree of "cure" is achieved.

e. Economic results of the sickness, especially a lessening of income, and an increase in expense.

These conditions make it necessary that in most cases of pulmonary tuberculosis the Family Doctor shall have the assistance of welfare and social agencies, both official and voluntary, in order to supply the patient with the financial relief, the encouragement, the will, and the knowledge which are necessary in order to enable him to persist in carrying out the advice of his physician.

PUBLIC RELATIONS OF THE FAMILY DOCTOR

The relations of the Family Doctor to the community, and to other agencies which give service to tuberculosis patients are shown in Chart 10. They are more extensive and comprehensive than those in any other branch of public health service.

The Family Doctor is the center of the system of tuberculosis control that is approved by The Medical Society of New Jersey. He is the person to whom a tuberculosis patient first applies for advice; and he has the opportunity to continue as the patient's personal adviser throughout the whole period of illness. An important part of his service will consist in bringing the patient in contact with the organizations which assist both the doctor and the patient.

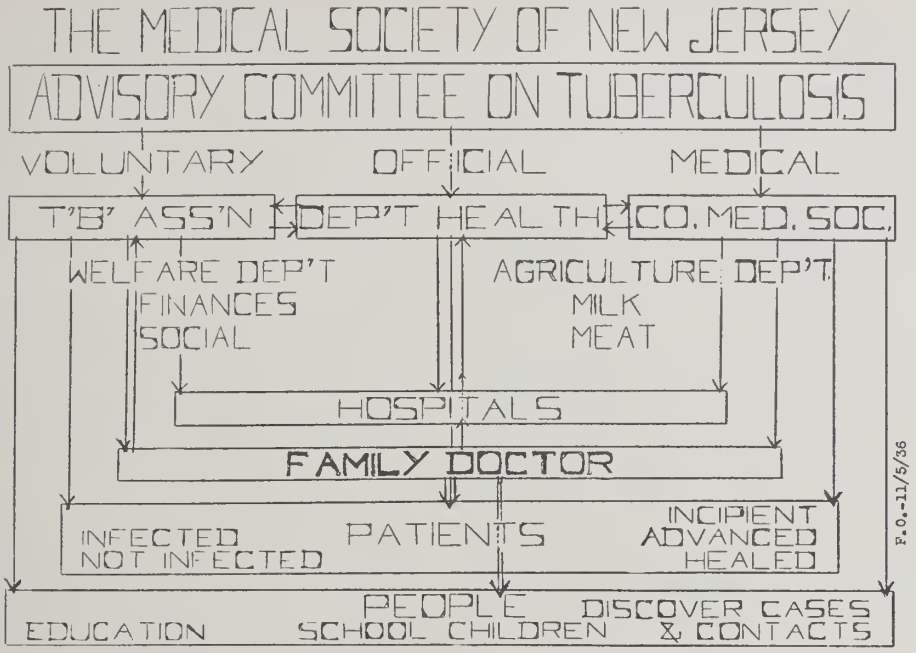


Chart 10.—The relations of the Family Doctor to other agencies engaged in the suppression of tuberculosis.

The agencies with whom the Family Doctor will come into intimate contact consist of three groups:

1. The medical societies of his county and the State.
2. Official agencies, including Departments of Health and Welfare; and tuberculosis hospitals and clinics.
3. Voluntary associations, particularly Tuberculosis Leagues, and Public Health Nursing Associations.

The Family Doctor will also be the center of circles of influence and instruction which he will radiate to the members of the families of the patient, and to all the people of his community. He is essential in educating the people in regard to the nature of tuberculosis and the part which they should take in its control.

It is sometimes difficult to secure harmony of action between organized agencies and the Family Doctor. The tendency is for lay organizations to assume the leadership, and the Family Doctor to willingly permit them to do so. A major object of this chapter of the Handbook is to indicate the ways and methods by which the Family Doctor may deliver his services to his tuberculosis patients with satisfaction to them and to himself.

THE COUNTY MEDICAL SOCIETY

The key *group* in the system of anti-tuberculosis service in New Jersey is the County Medical Society, of which Family Doctors constitute the majority of members. An essential service of the Society is to adopt a plan of action, and enter into agreements with each organization regarding the scope of its work in carrying out the program. The society shall perform the following duties of a general nature:

1. Assume the status of the friendly medical adviser to all other health groups that are engaged in any phase of anti-tuberculosis work.
2. Define the field of work of each agency, and the relation of the Family Doctor to it.
3. Act as a friendly arbiter between a Family Doctor and a health agency, in deciding questions in dispute.
4. Take a leading part in solving such problems as the construction of hospitals, the establishment of clinics, and the initiation of any new activity which is of special importance, or which involves a new line-up of the several agencies.

ANTI-TUBERCULOSIS ORGANIZATIONS

It is impossible that the Family Doctor can deliver *all* the varied services of medicine that are required for the treatment of a case, or the protection of the public.

However, in every community in New Jersey agencies are available to assist him and his patients in carrying out diagnostic, therapeutic, social, and relief measures. These classes of agencies are as follows:

a. *Departments of Health* shall provide the

more expensive means of diagnosis and cure, including tuberculin, x-rays, hospitals, and expert consultants.

b. *Departments of Welfare* shall provide the funds for the support of the patient and his family when the income is lowered on account of the sickness.

c. *Voluntary health agencies* shall educate public opinion, assume the leadership in campaigns, and influence governmental agencies and private persons to provide funds for carrying on the work.

d. *Public health nurses* shall visit the sick and the infected in their homes, and follow up partly-cured cases, and obtain lists of those who may have been in close contact with patients. In every visit the nurse shall take pains to state that she is acting for the Family Doctor, and shall inform him of the progress of his patients.

e. *Departments of Agriculture* shall eradicate tuberculosis from animals in dairies and stock farms, and assure the wholesomeness of milk and meat.

f. *School authorities* shall provide the means for making efficient examinations of school children suspected of having tuberculosis.

g. *Office holders generally* shall provide funds for carrying on anti-tuberculosis work, and pass laws and regulations for the control of patients who spread tubercle bacilli.

h. *Educators and lecturers* shall inform the people of the nature of the disease, and the means of its prevention and cure.

i. *Women's clubs* and local health organizations shall lend their support and inspiration to the campaign against the disease. The Family Doctor may call on any of these agencies for assistance. He properly expects a report on the service given in response to his request.

REPORTING CASES

Tuberculosis is on the list of diseases which the Family Doctor reports to the Department of Health; but as a matter of fact, only those patients in whom the tubercle bacilli are discharged from the body can spread the disease. The Family Doctor will therefore place every case in one of two classes:

1. Non-infective to other persons.
2. Infective.

The principle on which a Family Doctor shall act in reporting cases of tuberculosis is that he shall consider all cases in an active stage of the disease to be infective.

The characteristic lesion produced by tubercle bacilli growing in the body is the *tubercle*,—a white globular body, the size of a small pinhead,—which the body itself produces in order to encase the bacilli as in a tiny box. If the defensive act is successful, the body deposits lime throughout the tubercle by a slow process of calcification, thereby killing the bacilli, but leaving the calcified tubercles permanently in the body, where they are readily seen under the x-ray.

If nature's defensive act of calcification is not successful, the tubercle may break down and release their bacilli into the bronchi, from which they are discharged with the sputum.

It is a rule that a case is to be considered reportable if there is a cough, or fever, or other evidences of activity of the disease process.

DISCOVERING THE SOURCE OF INFECTION

An essential duty of the Family Doctor in tuberculosis, as in any other communicable disease, is to discover the *source* of the infection. This he will do by searching for previous cases with whom the patient has come into close contact.

Tuberculosis "goes through" a family because a parent, or relative, or servant has the disease and has given the bacilli to other persons. It frequently happens that a school teacher may be unaware that she has tuberculosis, and yet may infect the children in her care. Continued contact with a tuberculous person multiplies the opportunities for infection and its extent. The discovery and removal of the source of infection therefore has a *therapeutic* value, as well as that of *prevention*.

It is the duty of the Family Doctor to search for the source of infection in every case of tuberculosis which he is treating.

Tuberculosis in Domestic Animals. In tracing the source of infection of a human case, the Family Doctor will remember that cattle and pigs are subject to tuberculosis, and that their milk or meat may produce tuberculosis in persons who eat the food.

DIAGNOSTIC PROCEDURES

When the Family Doctor is confronted with a patient whose symptoms are suggestive of tuberculosis, he will at once take steps to make a diagnosis. Five measures are available to every physician in New Jersey:

1. A history of the case.
2. A physical examination of the patient.
3. An x-ray of the chest.
4. A sputum examination for tubercle bacilli.
5. A tuberculin test.

CASE HISTORY

Every Family Doctor will take a medical history of a patient. This will include the patient's possible exposure to a case of tuberculosis, and a record of any period of sub-normal health which he has had, especially while he was an infant, or in his early "teen" age.

PHYSICAL EXAMINATION

Every Family Doctor is equipped to make a *physical examination* of the chest, although it is of great advantage for him to have an "ear" for music, especially for pitch and quality of sounds.

In making a physical examination of the chest, the Family Doctor will keep in mind the following procedures:

1. Make the examination in a room that is *quiet*.
2. Strip the patient to the waist, for the sounds made by the clothing are often like those originating within the chest.
3. Take at least *ten minutes* to make an examination of the chest; and confirm each suspicious sign by repeating the examination of that area.
4. *Percussion.*—The percussion sounds vary over different areas of the chest. Percuss an area, and at once percuss the same area on the opposite side of the chest and compare the two notes.
5. *Palpation.*—The vibrations set up by breathing and the voice are transmitted from an area of solidification more plainly than from similar area of normal lung.
5. *Auscultation.*—The normal sounds of breathing and the voice are modified by abnormal processes within the lungs or bronchi. Always compare the sounds heard on one side of the chest with those on a similar area of the opposite side of the chest.

Râles are sounds which are not produced in a normal lung, especially those made by air bubbling through mucus; and those made by the friction of the two layers of the pleura. The most diagnostic râles in early or mild cases are those which are heard at the beginning of an inspiration following a mild cough done at the end of an expiration.

Making a physical examination of the chest is like playing a musical instrument, and requires skill in eliciting the sounds; an ear receptive to pitch, quality and intensity of tones; and a knowledge of the relation of the sounds to pathological changes within the chest. Opportunities for practicing the technic of the examinations and interpreting the findings are afforded the Family Doctor through his participation in local diagnostic clinics.

X-RAY EXAMINATION

An x-ray examination of the chest is one of the most reliable means of detecting early tuberculosis. Machines for generating the rays are available in every section of the State, either in the offices of physicians or in clinics and hospitals.

An expert will be able to judge the condition of the chest by a *fluoroscopic examination;* but usually an x-ray plate is better; and has the advantage of being a permanent record which can be referred to a consultant, or kept for comparison with those made later in the course of the disease. An x-ray examination may reveal abnormal conditions which are not evident by any other method of examination.

SPUTUM EXAMINATION

Finding tubercle bacilli in the sputum, or urine, or other excretions, or in discharges from an open sore, establishes the diagnosis of tuberculosis in an *infectious* stage. This examination is a technical procedure and requires facilities which the Family Doctor does not usually have. The State Department of Health will supply sputum containers to Family Doctors, and will examine specimens which are sent to the State Laboratory.

Cultures.—A positive diagnosis of tuberculosis can be made when tubercle bacilli are found in a *culture* made from the sputum or the excretions; but this test is usually impractical, for it takes days of time instead of hours as in diphtheria.

Inoculation Tests.—Inoculation of a guinea pig or rabbit with material from a human lesion may give positive evidence of tuberculosis; but it is seldom practical to apply the test, for it requires days of time, and an extensive laboratory equipped for animal experiments.

THE TUBERCULIN TEST

The tuberculin reaction is a form of allergy which shows that the products of tubercle bacilli have been absorbed into the blood stream. While the test is extremely sensitive, the degrees of the reaction and their interpretation vary according to the method of its use, and the skill and experience of the person giving it and reading the reaction.

The form of tuberculin tests which is approved by the Advisory Committee on Tuberculosis is that of *Dr. Mantoux*. The standard material chosen for this test in New Jersey is the tuberculin which is the concentrated germ-free culture medium in which tubercle bacilli have grown. It is a standard pharmaceutic preparation, and specific directions for its use are printed on its containers. It is diluted to

a one per cent solution, a drop of which is injected *intra-dermally,* on the fore-arm.

A positive reaction consists in a red area appearing around the site of the injection after a few hours.

Interpretation.—A positive reaction to a tuberculin test means that tubercle bacilli have grown in the tissues of the body at some time in the life of the person tested. It does not indicate how numerous the germs were; or how much damage they have done; or whether or not they are still active in the body. Its principal value is to discover those children who have been infected with tuberculosis, and therefore require a careful examination.

DIAGNOSING TUBERCULOSIS IN THE TEEN AGES

The mortality and morbidity rates for tuberculosis have been lowered in all age groups except among girls and boys in the "teen" ages,—13-19. The public schools offer the most practical opportunity of lowering these rates, for three reasons:

1. The law already requires that an examination be made of all school children and youths.

2. All children, and all youths in their early "teen" ages are required to attend school, and therefore they can be easily reached for examination.

The Committee on Public Health of The Medical Society of New Jersey has conferred with the representatives of the State Departments of Health and Education; and the New Jersey Tuberculosis League, and has agreed with them to promote the examination of school children of the "teen" ages, according to the following method:

1. The girls and boys shall obtain the consents of their parents to undergo the examination.

2. A tuberculin test shall be made on each student by physicians who are expert in giving and interpreting the Mantoux test according to a uniform method.

3. Each student in whom the Mantoux test is positive shall be given an x-ray examination, either with individual celluloid films; or by the rapid mass method of paper films.

If paper films are used, those found positive or suspicious, shall be given a re-examination by the use of celluloid films.

4. A careful physical examination shall be made on each student that is found positive by the x-ray examination.

5. Each student on whom a positive diagnosis of tuberculosis in any degree of activity is made, shall be referred to his Family Doctor for treatment.

(For a discussion of the method, see The Journal of April, 1936, p. 222.)

The part which the Family Doctor shall take in these examinations is three-fold:

1. Advise the parents to consent to the application of these texts.

2. Insist that reports of positive tests on his own patients shall be made to him.

3. Be ready to give advice and treatment to his patients who are reported positive to the tests.

STAGES OF TUBERCULOSIS

A Family Doctor will classify his tuberculosis patients into five groups:

1. Infected.
2. Incipient.
3. Advanced.
4. Arrested.
5. Healed.

Nearly all adults and about one-half of all children are in group one, and their infection may have little significance unless a follow-up x-ray is also positive.

The cases in groups two, three, and four require the careful attention of the Family Doctor.

It is doubtful that any person who has been seriously sick with pulmonary tuberculosis may safely be placed in group five; but the Family Doctor should keep the patient under observation. However, routine x-ray examinations of the chests of healthy persons often reveal large numbers of calcified nodules which are the healed lesions of an unrecognized attack of tuberculosis.

The Family Doctor will carry out the treatment which is indicated for each group of patients.

GIVING PREVENTIVE ADVICE

The Family Doctor shall instruct the patient and the members of his family in regard to the precautions which they shall take in preventing the spread of the disease to others, especially in regard to coughing, the use of a handkerchief, the disposal of the sputum, and the necessity that the patient shall sleep in a room and bed by himself.

TUBERCULOSIS HOSPITALS

Tuberculosis hospitals, constructed and maintained at public expense, are necessary for three reasons:

1. As a medical hospital to provide the means for giving scientific treatment to all classes of people, especially those who cannot stand the expense of prolonged treatment.

2. As a school to instruct the patients in the

theory and practice of the personal measures which they shall adopt for their own cure, and for the protection of the public against the spread of the disease.

3. As a demonstration to Family Doctors of methods of examination and treatment.

NEW JERSEY INSTITUTIONS FOR TUBERCULOSIS PATIENTS

Institution	*Bed Capacity*
State Sanatorium	
New Jersey Sanatorium for Tuberculous Diseases, Glen Gardner	492*
County Sanatoria	
Atlantic County: Pine Rest Sanatorium, Northfield	50
Bergen County: Bergen Pines Hospital, Ridgewood	254*
Burlington County: Fair View Sanatorium, New Lisbon	121
Camden County: Lakeland Sanatorium, Lakeland	255*
Essex County: Essex Mountain Sanatorium (opened as Newark City Sanatorium in 1908), Verona	439
Hudson County: Hudson County Tuberculous Hospital and Sanatorium, Secaucus	207
New Medical Center unit at Jersey City	550
Middlesex County: Roosevelt Hospital, Metuchen	200
Monmouth County: Allenwood Sanatorium, Allenwood	100
Morris County: Shonghum Mountain Sanatorium, Morristown	50
Passaic County: Valley View Sanatorium, Paterson R. F. D.	225
Union County: Bonnie Burn Sanatorium, Scotch Plains	392*
Local Sanatoria	
Burlington County: Brown's Mills Nursing Cottage	52
Deborah Sanatorium, Brown's Mills	42
Manor Nursing Cottage, Brown's Mills	40
Sycamore Hall, Brown's Mills	23
Mercer County: Mercer Tuberculosis Sanatorium, Pennington	82
Monmouth County: Farmingdale Preventorium, Farmingdale	250*
Morris County: Idylease Sanatorium, Newfoundland	60
General Hospitals	
Essex County: Newark City Hospital pavilion	24
Hudson County: Medical Center, Jersey City	71
Middlesex County: St. Peter's Hospital, New Brunswick	37
Passaic County: Paterson Municipal Hospital	25
Other Hospitals	
Essex County: Isolation Hospital, Belleville	30*
Mercer County: Municipal Colony, Trenton (1911) Rebuilt	100

*Of these the following beds for children are available: Glen Gardner, 120; Bergen Pines Hospital, 60; Lakeland Sanatorium, 79; Bonnie Burn Sanatorium, 141; Farmingdale Preventorium, 250; Essex County Isolation Hospital, 30.

Beds for crippled children including those crippled by non-pulmonary tuberculosis are available in the following institutions: Children's Seashore House, Atlantic City; Betty Bacharach Home, Longport; Hospital and Home for Crippled Children, Newark; New Jersey Orthopaedic Hospital, Orange (with its convalescent home at Westfield); Orthopaedic Hospital, Trenton.

DIAGNOSTIC CLINICS

It is desirable that a diagnostic clinic be held once or twice in each year, in each city, and important village or center of population, according to the following methods:

1. Their time, place, and medical examiners shall be approved by the County Medical Society.
2. The assisting personnel shall consist principally of representatives of the voluntary health associations, and they shall be the principal agents that bring patients to the clinic.
3. Every patient who is examined shall either bring an authorization from his Family Doctor; or shall be required to name a physician whom he will consult as his Family Doctor.
4. The examiner in hospital or clinic shall report his findings to the Family Doctor only; and shall instruct the visiting nurse to go to the Family Doctor for information.

In order to carry out this provision for giving information regarding the physical findings, it is necessary that the County Medical Society shall enter into agreements with the examining physicians and the coöperating organizations that they will observe these procedures.

TREATMENT OF TUBERCULOSIS

The three lines of treatment of tuberculosis cases in the order of their importance and field of application are:

1. Hygienic.
2. Medical.
3. Surgical.

HYGIENIC MEASURES

A minimum degree of motion within an affected lung is necessary for its healing, as it is in any other part of the body. This can be attained only by rest of the entire body,—physically, mentally, and emotionally. The Family Doctor can usually arrange for the patient's freedom from exertion physically and mentally; but he cannot always control the *emotional* strains caused by the anxiety and worry of the members of the patient's family. The Family

Doctor will therefore seek the aid of nursing and welfare organizations in order to secure rest for the body and repose for the mind of the patient.

If the patient cannot secure rest and repose for the patient at home, the Family Doctor may properly prescribe a "change of climate", —which, however, may defeat its own purpose by imposing an unbearable burden of loneliness upon the patient who is removed from his congenial associates.

The Family Doctor will also promote the normal functions of the body by advice regarding its proper nourishment, and the elimination of its wastes.

MEDICAL TREATMENT

The Family Doctor will prescribe sedatives and other medicines that will be of assistance in relieving cough and pain and in promoting the normal functions of the organs, including those of the nervous system.

SURGERY

Lung surgery is done for three purposes:

1. To remove liquid or purulent effusions from the pleural cavity or abscesses of the lungs. The Family Doctor may be able to perform the more simple operations in the patient's home; but more often they require the removal of the patient to a hospital.

2. To secure the collapse of a lobe of a lung in order to place it at rest and permit cavities and dilated bronchi to collapse and heal. This may be done by the resection of a rib, or the injection of air or a bland oil into the pleural cavity; but the operation is not effective if there are extensive pleural adhesions which bind the lung to the chest wall, and prevent its collapse.

Operations for the collapse of the lung are to be done only in a hospital and by experienced operators.

3. Resection of a diseased portion of a lung is in its experimental stage, and can seldom be done successfully in the present stage of lung surgery.

EDUCATING THE PEOPLE

The Family Doctor will not have done his full duty in relation to tuberculosis unless he takes an active interest in measures for instructing the people regarding the nature of tuberculosis and the measures which are necessary for its control. This educational work will be done principally by his coöperation with voluntary agencies.

The first group to be reached by educational methods are officials on the administrative boards of the political districts,—the towns, villages, cities, counties, and the State.

The second group consists of the citizens generally, especially the voters who elect the officials.

Three methods of arousing public sentiment for the support of anti-tuberculosis measures of a public nature are:

1. Campaigns for the establishment of local clinics, hospitals, summer camps, and other institutions for the care of cases.

2. The ordinary means of educating the public regarding health,—newspaper articles, lectures, and radio broadcasts.

3. Above all, the active support and leadership of the Family Doctor both individually, and through his County Medical Society.

B. S. Pollak, *Chairman*
Samuel B. English
J. R. Morrow
Frederic W. Lathrop
J. F. Pessel
George M. Levitas

CHAPTER EIGHT

CANCER CONTROL

Henry B. Orton, M.D., Newark, Chairman, Advisory Committee

Responsibility of the Family Doctor.
Chart of Public Relations.
Pre-Cancerous Stage.
Localized Stage.
Disseminated Stage.
Diagnosis.
Treatment.
Program of Cancer Committee.
Popular Education.
Cancer Survey.

One of the major problems in public health today is *cancer*. As a cause of death cancer ranks second; it is only exceeded by one other, and that is heart disease, having jumped in the last decade from sixth place to the second. This may be largely because of the growing proportion of persons now reaching the cancerous age.

It is well known that cancer may attack any part of the body and may be characterized by various types of tumor. Cancer differs from most other diseases in that its onset is insidious, its progress continues unless checked, and spontaneous cures seldom or never occur. The first requisite in its management of cancer is *diagnosis;* and modern science has provided the means of diagnosing cancer in most of its forms, and of treating it successfully if treatment is begun at an early stage.

RESPONSIBILITY OF THE FAMILY DOCTOR

It has been pointed out by various writers on the subject of cancer that the avoidable delay elapsing from the time the patient first notices a tumor, to the time of seeking medical advice, is approximately four months. Also it has been pointed out that the avoidable delay between the date of the first examination by the physician to the time the patient receives proper and efficient treatment is approximately four months; so that the total avoidable delay before correct treatment is instituted averages from eight months to a year. Active interest in cancer is therefore of vital importance to the Family Doctor, for the reason that most, if not all, patients have consulted him while the disease was in an early stage; and in a vast majority of cases, proper treatment applied then could have been effective. The detection and cure of cancer will depend upon the Family Doctor quite as often as upon the specialist in the disease.

The Cancer Committee of The Medical Society of New Jersey is prepared to assist its members in both diagnosis and treatment. The committee aims to make the Family Doctor "cancer conscious", so that he will think of cancer as a possible cause of any obscure condition which he is treating.

PUBLIC RELATIONS OF THE FAMILY DOCTOR IN CANCER

The public relations of the Family Doctor in cancer control are shown in Chart 11.

The primary and dominant contact of the Family Doctor in cancer is that with his *Patient*. He is at the center of the plans of the Cancer Control Committee of The Medical Society of New Jersey. He delivers the services of diagnosis and therapeutics to the cancer patient, or acts as the agent for their delivery by a specialist, or by a hospital that is properly equipped.

The Family Doctor is also the center for instructing the people regarding the nature of cancer and the means of its diagnosis and cure. He delivers educational service of essential value by two methods:

1. By promptly diagnosing and treating conditions which may be or are cancer.

2. Coöperating with his county medical society and its Speakers' Bureau, and with civic groups in conducting educational work among the people.

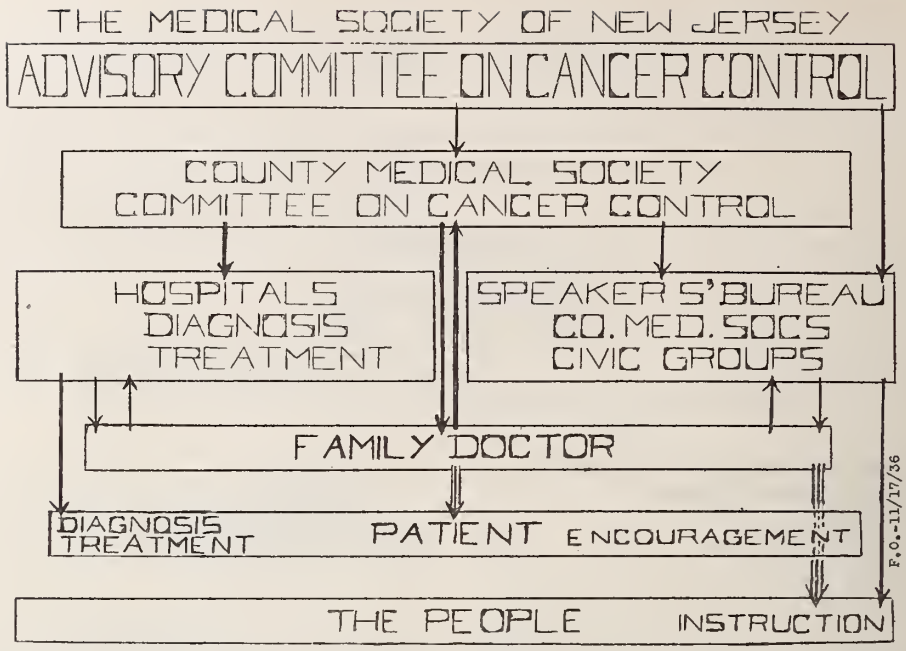


Chart 11.—The relations of the Family Doctor to other health agencies engaged in cancer control.

THE PRE-CANCEROUS STAGE

It is important that the Family Doctor should think of every case of cancer as existing in one of three stages:

1. Precancerous.
2. Localized.
3. Disseminated.

It may be unscientific to speak of cancer as existing before it is a cancer, or to say that a condition may "turn into cancer"; but the fact is that an irritation, long continued, often produces a cancer—as cancer of the tongue or cheek from long irritation by a sharp tooth, or an ill-fitting dental plate, or cancer of the stomach following a peptic ulcer. It is the evident duty of a Family Doctor to recognize the possible threat of these conditions, and to treat them before they have stimulated the development of an actual cancer.

THE LOCALIZED STAGE

At its beginning nearly every cancer is confined to a small part of the body, and manifests itself in one of three forms:

1. A chronic inflammation, of some part, such as the cervix.
2. An ulcer, as for example, cancer of the lip.
3. A tumor such as a "lump" in the breast.

If a cancer is localized in an accessible part of the body, it may usually be recognized early, and may be successfully treated by curative agencies applied directly to it, or by its removal by surgery.

THE DISSEMINATED STAGE

Material from a cancer may be carried by the blood or lymphatics to a distant part of the body and there produce secondary cancers, too numerous, or too deeply seated, to be reached. Although the probability of cure decreases rapidly with the duration and progress of the original cancer, yet many cancers in an advanced or disseminated stage respond to treatment.

PRACTICAL SUGGESTIONS TO THE FAMILY DOCTOR

Having in mind the three stages of cancer, the Cancer Committee offers a few suggestions for its control. To *look and see* is better than to *wait and see.*

1. Be suspicious of any tumor anywhere, and any sore on the skin or mucous membrane that does not heal within two weeks. Be especially suspicious of any sore on the lip; or of any wart or mole that is changing its character or size.

2. Absence of pain in the tumor or sore does not mean absence of cancer. Almost all cancers are painless at the beginning.

3. Cancer and tuberculosis may co-exist; and cancer frequently develops in syphilitic patient.

4. The cause of any vaginal discharge must be determined; cervicitis commonly precedes cancer.

5. Any irregular bleeding from the vagina, no matter how slight, should raise the question of cancer. Lugol's solution test may be useful in ruling out cancer.

6. Bleeding from the uterus or vagina occurring after the menopause is likely to be due to cancer.

7. Bloody urine is suggestive of cancer, and its cause should be determined. An x-ray study and cystoscopic examination are usually necessary.

8. Blood-stained stools, or bloody mucus, or painful, frequent or difficult defecation, should lead to an immediate careful investigation of the rectum and bowel.

9. Investigate the cause of any prolonged indigestion, especially after the age of forty. An x-ray examination is essential.

10. Vomiting of blood is always a danger signal. Its cause must be determined.

11. A complaint of bleeding piles often means cancer. Make at least a digital examination.

12. The cause of difficulty in swallowing must always be investigated. This is best done by an x-ray examination, or an esophagoscopy.

13. Any abnormal sensation persistently felt in the throat should be regarded seriously.

14. The expectoration of blood without fever may mean cancer of the lung. Fever is commonly present late in cancer. Pain in the upper part of the chest, neck, or shoulder may be due to cancer. An x-ray study is essential, and bronchoscopy. Be suspicious of an unproductive, unexplained cough.

15. Be suspicious of hoarseness not definitely due to a cold, or if continued more than two weeks. Careful examination of the larynx must be made.

DIAGNOSIS

Three diagnostic procedures are available in suspected cancer:

1. A complete history and physical examination of the patient.

2. An x-ray examination to determine the presence of a tumor of the internal organs.

3. A biopsy or microscopic examination of a small amount of tissue cut from a suspected cancer.

It is the duty of every Family Physician to take an accurate history, and make a physical examination of every suspected case; but many doctors may need help in obtaining and interpreting an x-ray picture of a suspected cancer, or in obtaining a specimen for biopsy. Few doctors have the equipment for making sections for microscopic study; but facilities for taking the specimens and examining them are available in many hospitals.

TREATMENT

Treatment must be not only prompt, but adequate. A little treatment because a lesion *may be* cancer is unjustifiable. Many lives are sacrificed by trifling with home remedies and other unscientific methods of treatment. Procrastination and incompetency usually mean failure.

The early application of proper treatment is very necessary for the cure of cancer. A cancer which may be curable during the first month becomes hopeless within six months.

Surgery, radium, deep x-ray therapy, and diathermy, either alone or in combination, are today the only recognized effective methods of treatment.

The original treatment must be carefully planned and meticulously followed. Secondary treatment after failure of the primary is rarely successful.

PROGRAM OF THE CANCER COMMITTEE

The Advisory Committee on Cancer Control has taken steps to provide an efficient system of cancer control involving the following features:

1. To organize and equip cancer clinics, both diagnostic and therapeutic, in the hospitals of the several counties, to which Family Doctors may send their patients for either diagnosis or treatment.

2. To provide that each county society shall:

a. Give the subject of cancer control a prominent place on its scientific program at least once a year.

b. Appoint a Cancer Control Committee.

3. To develop hospitals for indigent cancer patients. (These are now the most neglected of all classes of patients.)

4. To organized a *Speakers' Bureau* whose service will be available throughout the State to any organization, either medical or non-medical.

The need for an extension of the diagnostic and therapeutic services in the several hospitals is shown by the following statistics compiled from a survey of 171 institutions in the State made by the Cancer Control Committee in 1936:

Number having a tumor or cancer clinic	20
Number having radium ranging from 23 to 209 milligrams	17
Number having radium privately owned by physicians	7
Number having deep x-ray therapy machines	30
Number referring their indigent incurable cancer patients to other states (New York and Pennsylvania)	24
Number of cancer patients in the hospitals of New Jersey during the past year	6124

These are some of the high spots showing the dire need for the earnest coöperation of all physicians in improving the cancer situation in New Jersey.

CANCER SERVICE DISTRICTS

The committee will use every effort to deliver its services to the patient through the Family Doctor. For this purpose, it has arranged its seven members to districts as follows:

District 1—Comprising the counties of Essex and Union, under the jurisdiction of the Chairman, Dr. Henry B. Orton, Newark.

District 2—Comprising the counties of Bergen and Passaic, under the jurisdiction of Dr. F. C. McCormack, Englewood.

District 3—Comprising the county of Hudson, under the jurisdiction of Dr. James H. Rosencranz, Hoboken.

District 4—Comprising the counties of Morris and Sussex, under the jurisdiction of Dr. John F. Condon, Newark.

District 5—Comprising the counties of Mercer, Hunterdon, Warren, Somerset and Middlesex, under the jurisdiction of Dr. J. H. Kler, New Brunswick.

District 6—Comprising the counties of Monmouth, Ocean and Burlington, under the jurisdiction of Dr. Carl Mange, Toms River.

District 7—Comprising the counties of Camden, Gloucester, Salem, Atlantic, Cape May and Cumberland, under the jurisdiction of Dr. E. E. Downs, Woodbury.

POPULAR EDUCATION REGARDING CANCER

A common attitude toward cancer is one of fear and helplessness, which is often the result of reading popular articles in newspapers and magazines on the early signs of cancer. As a matter of fact, most persons who suppose that they have cancer do not have one at all, but they have a sore, or a discharge, or a benign tumor which may be cured by simple means if the patients will consult their Family Doctor.

On the other hand, if an actual cancer exists, it is usually discovered by the Family Doctor in a patient who does not suspect its existence or even its possibility. A responsibility rests upon every Family Doctor to correct the fears of his patients, and to arouse hope in each one who suspects that he may have cancer, but yet shuns the physician lest his suspicions may be confirmed. The Family Physician has the opportunity to correct the false impressions of the people toward cancer, just as he has changed the popular attitude toward tuberculosis.

Henry B. Orton, *Chairman*
F. C. McCormack
James H. Rosecrans
John F. Condon
Carl Menge
J. H. Kler
E. E. Downs

CHAPTER NINE

VENEREAL DISEASE CONTROL

Charles H. deT. Shivers, M.D., Atlantic City, Chairman, Advisory Committee

Field of Service.
Facilities for Diagnosis and Treatment.
Epidemiology.
Action by County Medical Society and by the Family Doctor.
Chart of Relations.
Syphilis,—Stages, Congenital.
Gonorrhoea,—Diagnosis, Treatment.
Vaginitis.
Ophthalmia.
Rheumatism.

THE FIELD OF SERVICE

The control of venereal disease, unlike that of tuberculosis, is predominantly a problem in medical service, in which the principal agencies are:

1. Physicians in private practice.
2. Official agencies, particularly the State Department of Helath, local health officers, and the United States Public Health Service.

The field of venereal disease has not been preoccupied by voluntary agencies; and Family Doctors and their medical societies are free to develop their own effective means for discovering cases and for treating them.

The Family Doctor is the key man in any comprehensive system of venereal disease control. The discovery of most cases must be done by Family Doctors to whom those who have the disease come voluntarily for diagnosis and treatment.

FACILITIES FOR DIAGNOSIS AND TREATMENT

The great progress in our knowledge of the symptoms and signs which are suggestive of venereal disease, and of effective means for their diagnosis and treatment, enables every Family Doctor to take an active part in the diagnosis and treatment of every venereal disease patient that comes to him. In nearly every instance, it is the Family Physician to whom the patient goes first for advice. There is, therefore, a direct challenge to every physician along two lines:

1. To privately suspect a venereal disease in every patient whose diagnosis is otherwise uncertain, and whose symptoms suggest the possibility of a venereal disease.
2. To take measures for making a correct diagnosis, and instituting the proper treatment.

The wise Family Doctor will not necessarily tell the patient of his diagnostic suspicions at first; but nevertheless, he will take the proper specimens of blood or excretions, and either examine them himself, or send them to a laboratory where the examination will be made.

Facilities for examining specimens of blood and excretions, and making physical examinations of the patients, will be made readily available in every community, either in the offices of certain physicians who are designated by the county society, or in clinics to be established and conducted with the approval of the county society. The United States Public Health Service, through its agents,—the State Department of Health, and the County Medical Societies,—already provides diagnostic and treatment facilities which are available to every physician, especially to those who do not wish to equip their offices with the necessary apparatus, or to use it themselves. This service is given quietly and without publicity to either the physician or the patient.

EPIDEMIOLOGY OF VENEREAL DISEASES

The Family Doctor will bear in mind the fact that both syphilis and gonorrhoea are *communicable* diseases. They are not only caught from previous cases of the disease, but also they may be spread to innocent persons who come in contact with active cases in the ordinary associations of life. They have therefore been made reportable diseases by the State Department of Health. The Family Doctor should consult his local health officer regarding the special rules for reporting his cases.

ACTION BY A COUNTY MEDICAL SOCIETY

The plan of action by county medical societies, adopted by the Advisory Committee on Venereal Disease Control of The Medical Society of New Jersey, may be outlined as follows:

a. Establish a Committee on Venereal Disease Control, which shall develop the details of the local service and its management in cooperation with a similar committee of The Medical Society of New Jersey, the State Department of Health, and the local health officers.

b. Aid properly qualified physicians to secure:

1. Drugs which are distributed through the State Department of Health.

2. Equipment for taking specimens for diagnosis and mailing them to the Laboratory of the State Department of Health, Trenton, N. J.

(It is understood that the diagnostic services supplied by the State shall be made available to any physician in his community.)

c. Assist in setting up clinics for the following purposes:

1. The diagnosis of obscure cases.

2. The diagnosis and treatment of indigents, and those of low incomes.

3. The instruction of physicians of the community regarding the medical and social aspects of the diseases.

d. Promote the instruction of Family Doctors in methods of diagnosis and treatment, either through the programs of county society meetings, or by demonstrations in physician's offices, and in clinics.

e. Arrange for the payment of physicians who conduct the clinics, or who treat patients of low incomes.

ACTION BY THE PRACTICING PHYSICIAN

a. Take active steps to inform himself regarding the diagnosis and treatment of venereal diseases.

b. Procure the equipment for the diagnosis and treatment of venereal diseases; and use it conscientiously and scientifically.

c. If he does not care to receive venereal cases, he shall refer them to a physician who is equipped to give diagnostic and therapeutic services; or to a clinic approved by the County Medical Society.

d. Coöperate with the local health officer in carrying out the public health procedures and regulations of the State Department of Health.

RELATIONS OF THE FAMILY DOCTOR

The relations of the Family Doctor to their venereal disease patients, and to other agencies engaged in serving them and the public, are shown in Chart 12.

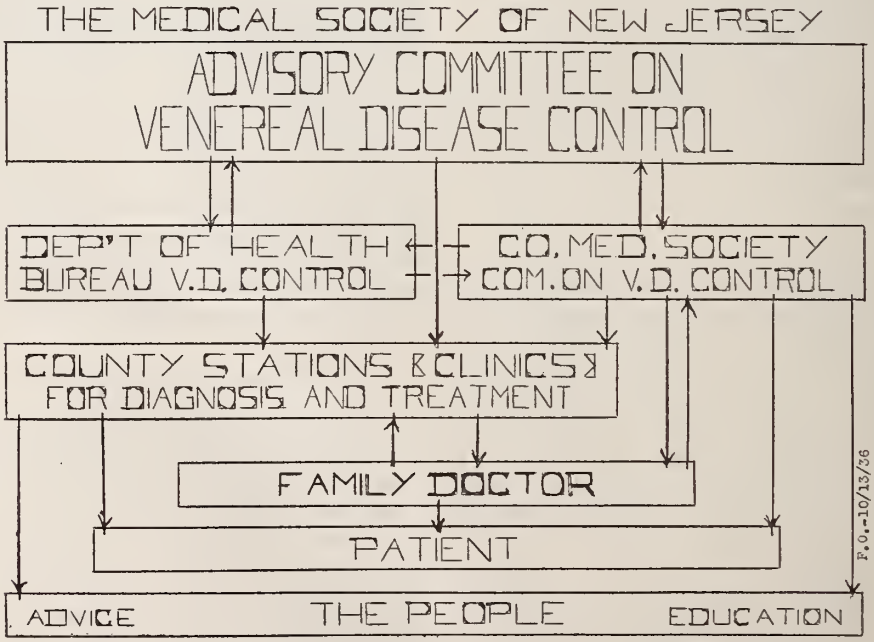


Chart 12.—The relations of the Family Doctor to other agencies engaged in the control of venereal diseases.

The arrows indicate that the Family Doctor is the principal agent in delivering medical service to the patient, although he may need assistance in the more difficult procedures in diagnosis and treatment.

He may call on the Committee on Venereal Disease Control of his County Medical Society for advice in regard to measures either administrative, or diagnostic, or therapeutic.

He may also call on the consultants, stations, or clinics, which are provided under agreements of his county medical society with the State Department of Health.

Since venereal diseases are still popularly considered to have *moral aspects,* the Family Doctor will use tact and discretion in educating the people by lectures and newspaper publicity; yet he will support his county medical society in community measures of popular education in the prevention and treatment of the diseases.

SYPHILIS

Syphilis manifests itself in varying forms according to the stage of the disease, whether it be primary, secondary, or tertiary.

A. THE PRIMARY STAGE

The primary form of syphilis is a sore located on the spot at which the microörganisms of the disease have entered the body. When the Family Doctor encounters a suspicious lesion, the standard procedures which he will apply are as follows:

a. Make a careful examination of the sore to determine its hardness and other characteristics, and the presence of enlarged lymphatic glands near it.

b. Curette the sore lightly and take a specimen of its serous exudation.

c. Examine the specimen under a dark-field microscope to determine the presence of the characteristic organisms; or

d. Send the specimen to a laboratory which is equipped to make the examination.

e. If the organisms are found, he will begin treatment at once, before the infective germs have spread to other parts of the body.

Promptness in diagnosis and treatment may be expected to arrest and cure the disease in its earliest stage.

B. THE SECONDARY STAGE

When the organisms of syphilis have entered the tissues of other parts of the body or the blood stream, they produce secondary forms of the disease, particularly a skin eruption, enlarged glands, and pain and tenderness, any of which may appear in any part of the body. When a Family Physician finds a patient with these suspicious signs, he will at once take the following steps:—

a. Take a specimen of blood and have it examined for the Wassermann reaction. If the patient has an open lesion, the Family Doctor will take a specimen of serum from it as he would from a primary sore, and have it examined as if it were from a primary sore.

b. If the specimen is reported positive, he will at once begin the treatment of the patient with mercury, or bismuth, or one of the preparations of arsenic; or

c. Refer the patient to a consultant or specialist, or a clinic.

d. Maintain a friendly contact with the patient in order to encourage him to persist in the treatment; and to take precautions against spreading the disease to other persons.

e. Report the case to the health officer according to the rules of the State Department of Health.

C. THE TERTIARY FORM OF SYPHILIS

After syphilis has developed for months or years, it may produce changes in any part of the body, especially the bones, or the organs of circulation and the central nervous system.

When a Family Doctor meets a patient with an abscure chronic affection which is suggestive of syphilis, he will take the following steps:—

a. Have a Wassermann test done.

b. If it is positive he will give a course of treatment which is suited to the case,—usually a course with one of the arsenical preparations.

CONGENITAL SYPHILIS

A Family Doctor giving pre-natal care to a pregnant woman who has syphilis will at once take steps to treat the mother for the benefit of the child,—both to save its life, and to prevent the development of the disease after birth.

Congenital syphilis is usually of the tertiary form, and is to be suspected when the child is poorly nourished without apparent cause; or has defective teeth or other characteristic signs of the disease.

If a Family Doctor has reason to suspect that one of his child patients has congenital syphilis, it is his duty to refer the patient to a consultant for the more expert forms of treatment.

How to discover and treat unsuspected syphilis in the tertiary stage is one of the gravest public health problems which confronts the Family Doctor today. Because the disease

usually yields to proper treatment, the Family Doctor will take an active interest in every one of his patients who has symptoms which are suggestive of the disease.

It is also the function of the Family Doctor to avail himself of the clinical instruction afforded by one of his cases, especially those whom he refers to a consultant or clinic.

GONORRHOEA

The Family Doctor is also charged with serious duties in regard to gonorrhoea. This disease has various manifestations in three groups of patients:—

a. Adult males.
b. Adult females.
c. Children and babies.

Its manifestations also vary according to the stage of the disease, whether it be:—

a. Acute; or
b. Chronic, especially gonorrhoeal rheumatism.

DIAGNOSIS

A Family Doctor is charged with the serious responsibility of making a diagnosis in every patient in whom he has reason to suspect gonorrhoea.

The most reliable indication of the disease is the presence of *gonococci in the excretions* of the affected part. The Family Doctor will make a dried smear of the excretions; and will either examine it himself under a microscope, or send it to the laboratory for examination.

The Family Doctor will also take smears to determine when a patient is cured.

TREATMENT

The Family Doctor will take an active interest in every patient in whom he has reason to suspect the disease; and will either treat the person himself, or refer the patient to a specialist or a clinic.

FEMALE INFANTS AND YOUNG CHILDREN

Gonorrhoeal vaginitis often spreads among female infants and young children when the original source of infection cannot be discovered. It is the function of the Family Doctor to take steps to diagnose and treat these patients.

GONORRHOEAL OPHTHALMIA

It is the function of every Family Doctor who attends a woman in child birth to apply preventive drops of a one per cent solution of silver nitrate to the eyes of every new-born baby. The general adoption of this procedure has made ophthalmia neonatorum a rare disease.

GONORRHOEAL RHEUMATISM

The Family Doctor will suspect a gonorrhoeal infection to be a possible cause of chronic arthritis, and will refer his patient to a consultant or clinic for diagnosis and suggestions for treatment.

INSTRUCTION

As in syphilis, it is the function of every Family Doctor to make a serious study of the various manifestations of gonorrhea, especially by observing the procedures that are applied in clinics, and by specialists to whom he refers his more difficult cases for diagnosis and treatment.

C. H. deT. Shivers, *Chairman*
Stanley R. Woodruff
Clarence O'Crowley
C. Byron Blaisdell
George N. J. Sommer
A. Haines Lippincott

CHAPTER TEN

MENTAL HYGIENE

James S. Plant, M.D., Newark, Chairman, Advisory Committee

Chart of Contacts and Relations of the Doctor.
A Comprehensive Program.
Insanity,—its causes, diagnosis, and management.
Legal Commitment of Patients.
Epilepsy.
Behavior Problems.
Tests for Mental Age.

The Medical Society of New Jersey is considering the problem of inspiring the Family Doctor to engage in the diagnosis and correction of abnormal mental states with the same interest and efficiency that he now takes in abnormal states of the physical body.

The word "Physician" originally meant one who dealt with physical defects of the human body; while the "Meta-physician" dealt with those conditions which were beyond the physical,—that is, the *mental.* The specialist in mental disorders is properly called a "Psychiatrist", from two Greek words, *psyche,* mind, and *iatros,* healer.

Psychiatry as a specialty has developed along lines which are divergent from those of physical medicine; and Family Doctors are often unfamiliar with its terminology and its language, though not more so than they are in ophthalmology and otology. There is a common ground of practice on which the Family Doctor and the Psychiatrist may meet with mutual benefit.

CONTACTS AND RELATIONS OF THE FAMILY DOCTOR

No plan of action is clear and comprehensible unless it can be visualized in a simple chart. The contacts and relations of the Family Physician in the field of mental hygiene is shown in Chart 13.

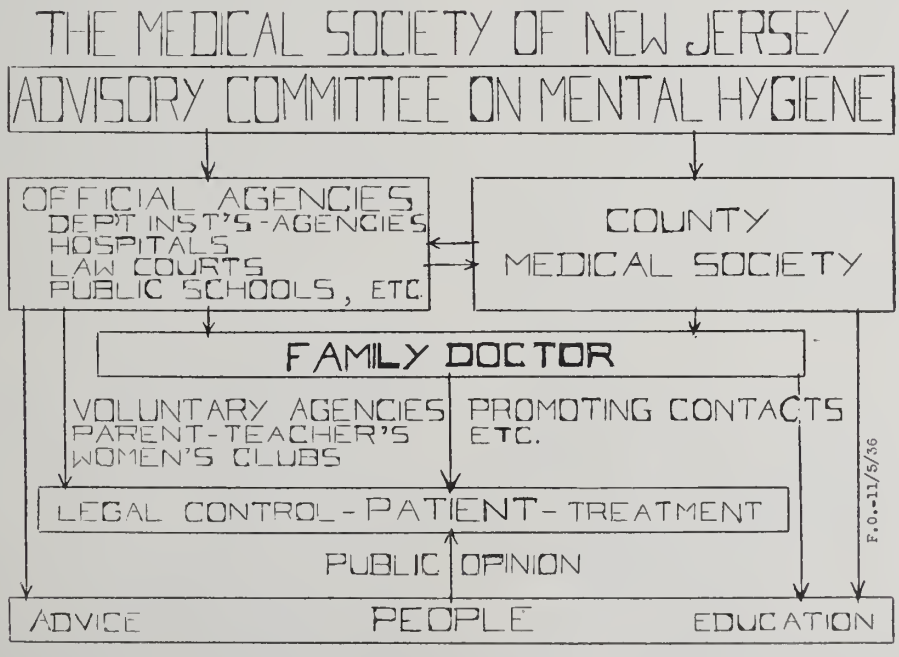


Chart 13.—The relations of the Family Doctor to other agencies engaged in mental hygiene

The Family Doctor is the central agency in the diagnosis and treatment of a mental disease patient. He will be in immediate charge of the treament of the patient, as he is in cases of appendicitis and pneumonia. He will call a psychiatrist in consultation, just as he would a surgeon in suspected appendicitis.

The Family Doctor will maintain a personal interest in his patient, even when he sends the patient to a hospital or other institution.

There are legal aspects in every severe case of mental abnormality involving family quarrels, divorces, financial failures, crime, and commitments to institutions. The Family Doctor will therefore come into contact with official agencies, especially in cases involving insanity, mental deficiency, truancy, and crime.

The Family Doctor may seek the aid of voluntary agencies, such as Parent-Teacher Associations, and Public Health Nurses, especially in dealing with the members of the families of the patients.

The Family Doctor also comes into close contact with the neighbors of the patient, and with the people generally, in securing their support of his treatment, and educating them in the principles of mental hygiene.

The County Medical Society shall act as the agent of the Family Doctor in securing agreements with the other agencies regarding principles of the medical treatment of patients, and the adoption of public measures for their care, such as building hospitals, and establishing diagnostic clinics in mental hygiene.

Practically every patient with a mental disease presents a problem in which the public is interested, because of his inability to adapt himself to the ways of society. It is the duty of the Family Physician to maintain his interest in the case for the benefit of the patient himself and also of the public.

The Advisory Committee on Mental Hygiene of The Medical Society of New Jersey suggests the following program in which all the groups concerned with mental abnormalities may participate, each performing a specific duty.

I. BY THE COMMITTEE ITSELF

A. Urge in every way it can, the further development of the present State program of Mental Hygiene clinics. This program is based on the sound principle that the part that the psychiatrist can play in the work of the Family Doctor can be demonstrated only by actual cases in the doctor's own community.

B. Support an educational campaign that involves:

1. Showing the Family Doctor that these clinics help him with his problems, rather than in any way compete with him.

2. Showing the Family Doctor that this clinic work should eventually be in his hands (and in the hands of his community). That is, the committee believes that the State-supported program should be only a means of developing local interest and support for such work.

II. BY PSYCHIATRISTS

A. The psychiatrists in mental hospitals should communicate periodically with the Family Doctor as to the progress of any of his patients in those institutions.

B. They should also inform the Family Doctor of the discharge of the patient, and give suggestions for continuing the doctor's observations and treatment.

C. They should coöperate with the Family Doctor in furthering the proper use of voluntary commitments. Voluntary commitment should be used where individuals *really desire* the help that can be obtained at a mental hospital—at the same time that this condition is not so serious as to warrant the ordinary legal commitment.

D. They should cultivate the friendship and confidence of Family Doctors, and invite them to bring their problem patients to the institution for examination and advice.

III. BY THE COUNTY SOCIETY

A. In those counties which are served by a Mental Hygiene clinic (or which are soon to have that service), they should appoint a subcommittee on Mental Hygiene to the County Public Health Committee, to work in coöperation with the State committee.

B. They should coöperate with the State committee in the development of lectures and demonstration wherever there are Mental Hygiene clinics already established.

IV. BY THE FAMILY DOCTOR

A. Meet the psychiatrist half way in his effort to give instruction and assistance in handling mental disorders.

B. Visit the mental institutions near him, and observe the work done.

C. Follow up the patients whom he sends to the public institutions.

D. Consult the list of institutions for mental disorders when in need of advice or assistance (page 55).

E. Do whatever he can to remove the prejudice of the people against the hospitalization of their relatives or friends.

F. Inform himself as to the curability of some of the abnormal mental states so that he

may influence patients to seek medical advice in the early stages of mental disorder.

While the program which calls for the demonstration of what help the psychiatrist can give to the Family Doctor through clinic demonstration is sound, there are steps in the field of prevention which the Family Doctor can take in the meantime. These might be summarized under the headings of insanity, epilepsy, feeble-mindedness, and conduct disorders.

INSANITY

It would be impossible to give any comprehensive picture of this group of troubles in a few paragraphs. We must admit that in some instances insanity is produced by:

1. Congenital or inherited instability of the nervous system.
2. Overwork and worry in those who are congenitally unable to endure extraordinary nervous strain.
3. Drugs such as opium, or the toxins of a physical disease, such as syphilis or encephalitis.
4. Trauma to the nervous system.

In these instances the Family Doctor has the responsibility:

1. To deal frankly and honestly with the family and the patient as to the nature of the trouble.
2. To explain the value of hospitalization and of getting help from psychiatrists.
3. To lessen the notion of stigma that today surrounds any illness involving the mind.

In many other instances, however, insanity undoubtedly follows the patient's inability to cope with some crisis. When unusual depression or exhilaration appear, delusions or vague hallucinations, persistent and unwarranted fears as to illness,—then the Family Doctor *must* attempt in friendly and understanding manner, to discover and ameliorate the social or personal crisis which is back of these troubles.

There is nearby help for him and he should cultivate the procedure of turning to those who are specialists in this aspect of medicine. The following is a list of the public hospitals for mental diseases in New Jersey:

State Hospital for Mental Diseases, Greystone Park, Morris County. Dr. Marcus A. Curry, Superintendent. Telephone Morristown 4-1800.

State Hospital for Mental Diseases, Trenton, N. J. Dr. R. G. Stone, Medical Director.

State Hospital for Mental Diseases, Marlboro, Monmouth County. Dr. J. M. Gordon, Medical Director. Telephone Freehold 229.

Essex County Hospital for Mental Diseases. Dr. Guy Payne, Superintendent. Telephone Humboldt 3-1505.

Hudson County Hospital for Mental Diseases, Jersey City. Dr. A. D. Orr, Warden. Telephone Palisades 6-5100.

EPILEPSY

What we usually term epilepsy is but one of a series of convulsive disorders, many of which are susceptible to complete and lasting cure under proper treatment. The Family Doctor may well follow the principle of refusing to make the diagnosis of epilepsy until (with such help as he may wish to get) he has positively ruled out metabolic, traumatic, or functional causes for the convulsions. It is very tempting to use some such drug as luminal to free the patient of the symptoms, when a more painstaking diagnosis would permanently clear up the entire condition. Moreover, many true epileptics can be maintained in the community with proper regimen and medication. If information as to where to seek help is needed, or the Family Doctor has decided upon hospitalization, he may turn to:

The State Village for Epileptics, Skillman, Somerset County. Dr. Dan S. Renner, Superintendent. Telephone Hopewell 181.

MENTAL DEFICIENCY

The milder forms of intellectual retardation do not necessarily lead to social inefficiency; indeed many of our more menial and automatic types of labor are efficiently carried through by this group. However, the intellectually retarded frequently have a serious time in adjusting themselves to the demands of school work; and in consequence truancy, rebellion, various forms of delinquency, "laziness", inattentiveness, etc., are frequently brought to the Family Doctor's door for assistance.

The usual tests for intelligence are too time-consuming for ordinary practice. However, the Family Doctor can use his influence towards having the local schools equipped with good psychological service. He will also find the nearest Mental Hygiene Clinic able and ready to give him help. The address can be obtained through any of the hospitals for mental diseases named above, or through

Commissioner William J. Ellis,
Department of Institutions and Agencies,
Trenton, N. J.

From the point of view of prevention the Family Doctor has one of his richest fields here. For that very large group of those who

will remain in the community, his resourcefulness is taxed to the utmost in keeping these children from becoming discouraged and bitter over school failure and unsuccessful competition for work. There is the further difficulty that the usual recreational outlets are often quite closed to this group, due to their retardation. For the group that will eventually need to be institutionalized he should press this step before some dreadful crisis forces it. The Family Doctor's evasion of responsibility through the assurance that "The child will outgrow it" leads only to disaster. The committee does not ask the Family Doctor to equip himself to diagnose these conditions; but there is help in the various clinics (school or state) and he must learn to turn to these.

STATE INSTITUTIONS FOR THE MENTALLY DEFICIENT

State Colony for Feeble-minded Males, New Lisbon, Burlington County. C. T. Jones, Ph. D., Superintendent. Telephone Pemberton 1.

For patients whose mental capacity is of a fairly high grade.

State Colony for Feeble-minded Males, Woodbine, Cape May County. Edward L. Johnstone, Superintendent. Telephone Dennisville 21.

For children of a low grade of intelligence, although many inmates have now reached mature ages.

New Jersey Training School, Little Falls, Passaic County. A. H. Meese, Superintendent. Telephone Little Falls 4-0800.

For feeble-minded females with a considerable degree of intelligence.

Vineland State School, Vineland, Cumberland County. George B. Thorn, Superintendent. Telephone Vineland 3.

For females of a low grade of intelligence.

In addition, several hundred mental defectives who are wards of the State are boarded in the Vineland Training School, of which Dr. Edward Johnstone is Medical Director. This institution is for both boys and girls, and receives those who have sufficient intelligence to respond to considearble training. It also conducts researches in problems of mental and unsocial behavior.

CONDUCT DISORDERS

The Family Doctor is consulted more and more for help in this vast field that begins with thumb-sucking or persistent enuresis, and runs the gamut of maladjustment up to running away or other serious delinquency. Here again is a time-consuming task, and one for which the Family Doctor will often have to turn to the Mental Hygiene Clinic. There are, however, certain fundamental principles to be remembered:

1. The more serious adult maladjustments —crime, insanity, social inefficiency—are usually heralded by some maladjustments in childhood; and on this account a program of prevention *must* include all help that we can possibly give to maladjusted children.

2. The child who steals, or runs away, or writes dirty notes in school, or persistently sucks his thumb—the child with a conduct disorder—is trying to solve a problem. Until we find the problem he is trying to solve we are making no progress.

3. Lectures to the child, "moralizing", various forms of threats, ponderous pronouncements about "being good" are no more useful than trying to bring down to normal the temperature of a pneumonia patient.

4. It is well to have faith in the child—to talk with him alone—to find out what he wants to do about the trouble—to get "his side of the story". Surprising as it may seem, in problems of enuresis it is the child himself who is wetting the bed—not his parents. It is well to *work out the problem with the child himself*. The child who truants is the one who is staying away from school—not his teacher or the truant officer.

5. Many of these problems are complicated and beyond the Family Doctor's means of handling. The Mental Hygiene clinics in New Jersey are equipped to help in this field without in any way cutting in upon any aspect of the handling of the patient which the Family Doctors feels ready and able to handle.

James S. Plant, *Chairman*
Dan S. Renner
Marcus A. Curry
J. B. Gordon
Matthew Molitch
George S. Stevenson

CHAPTER ELEVEN

HEALTH EXAMINATION OF ADULTS

Francis H. Glazebrook, M.D., Morristown, Chairman, Advisory Committee

Period of Adult Life.
Increased Life Expectancy.
Chart of Relations.
Minimum Procedures.
A Health Examination Outline.

The subject of health promotion is constantly urged upon the people by physical trainers, writers for magazines and newspapers, and advertisers of cosmetics and health foods, who emphasize the outward aspects of physical form, beauty, and attractiveness, from the point of view of the athlete, the artist, and the showman. These conditions are of minor interest to the Family Doctor,—his concern is for the comfort and efficiency which a person experiences when the physiological functions of his internal organs are normal.

THE PERIOD OF ADULT LIFE

The period of adult life, like that of infancy and childhood, has health problems and hazards which are characteristic of mature age. People are eager to consult their Family Doctor for conditions which are distinctly uncomfortable, or impair the efficiency of their work; but they are not accustomed to avail themselves of the preventive services which they expect for their babies.

The Family Doctor is prepared and eager to deliver his services to those who are impelled to seek his advice for obvious sickness or crippling conditions. The scope of his responsibility extends also to conditions and degrees of *health,* as well as of *disease,* of adult persons, as is exemplified in the examinations in life insurance, and the examinations of applicants for employment in hazardous industries. The Family Doctor has the opportunity and duty to broaden his field of practice so as to include the examination and treatment of adult persons who are apparently healthy.

INCREASED LIFE EXPECTANCY

Convincing evidence of the efficiency of medical services is the fact that the average life expectancy at birth has increased ten years in the last generation. Each person born today has a life expectancy of fifty-nine years. This lengthening of life is due to the reduction not only in infant mortality, but also in the incidence of acute illness and its sequelae in people of all ages, through methods of prevention and better understanding of pathology and specific therapy.

This has resulted, on the other hand, in an increase in the incidence of the so-called *chronic diseases* after the third decade of life. This fact is explained in part by the fact that a greater number of individuals are reaching the *age period* of such diseases; but a more important factor is the greater stress and manner of living of modern days. It is likely that any material increase in the span of life in the future must come largely from earlier diagnosis and treatment of the so-called *degenerative diseases* of middle life, and from control of the habits of the people at large.

To accomplish the objective of larger and healthier life, there must be widespread education regarding personal hygiene and the mode of living. This demands an increased concern on the part of the Family Doctor along the lines of personal hygiene; and the inculcation of a method of living which enhances good health, and delays the process of growing old. The medical profession must assume this obligation, for it is as essential as the ability to treat sickness. The aim of every Family Doctor should be to inspire each of his patrons with a hope that his life may be "abounding with vitality, endurance, and the spirit of optimism and invincibility, which can only be if one has effectively working bodily organs".

The doctor's concern today must be "Not only the sick and diseased body; but also the normal body as a well unit, and the ideal—*the human body always well*".

It is difficult to impress upon the public the importance of taking a health inventory from time to time. Each person feels that such procedure is not necessary in his own case; and yet those of us who, as part of our work, examine large numbers of people seeking employment in a business organization, very often find advanced organic disease in individuals who believe that they are well. The science of medicine has developed to such a degree that its standards require the Family Doctor to apply his available knowledge and skill in the detection and correction of the obscure physical defects of his patients.

RELATIONS OF THE FAMILY DOCTOR

Chart 14 shows the relations of Family Doctors to other groups engaged in the project of health examinations of adult persons. This relation is almost entirely *individual,* in contrast with the participation of other groups as, for example, in the activities in child health, crippled children, and tuberculosis. The service is essentially a *personal* one, given by an *individual* doctor to an *individual* person; and will not require reports be made, on other organizations to coöperate.

About the only group whose coöperation is required is the County Society, which will promote the education of the people generally as to the scope of the examination and its value to the individual. The essential part of the Family Doctor in educating the people is twofold:

1. To be prepared to deliver the service to those who request it.

2. To inform the members of the families on his calling list of the value and scope of the examination.

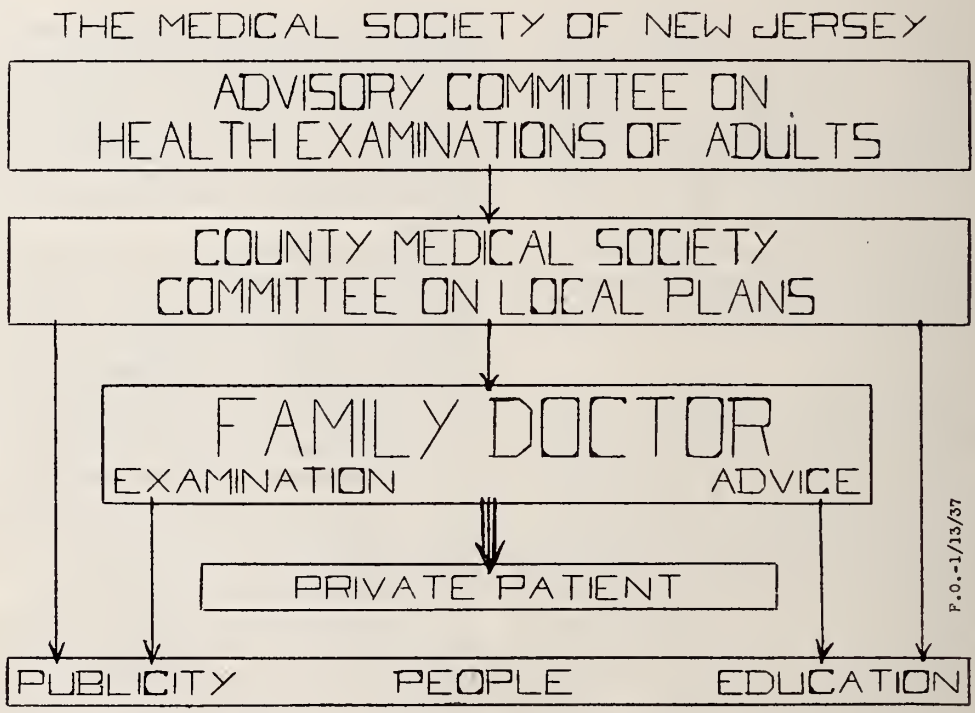


Chart 14.—The relations of the Family Doctor in the examination of adults who are presumably healthy.

MINIMUM PROCEDURES BY THE FAMILY DOCTOR

In outlining a minimum service for the Family Doctor to give in the field of adult health supervision, the following procedures seem essential:

1. He will make an inventory of the person's present state of health, in order that he may know how to correct impairments of health.

2. With the inventory of the present health status before him, the Family Doctor will aim to correct all correctable defects, and to advise concerning, and continuously supervise, noncorrectable defects.

3. He should apply the measures which are available to prevent sickness and bodily impairment, such as the elimination of infective foci, building up a body resistance, rehabilitation of those who are on the downward grade,

and immunization and desensitization where such procedures are possible.

4. The Family Doctor should make a study of the detailed habits of the individual, with advice and correction concerning the harmful effects of his bad habits.

5. The Family Doctor should follow-up all his patients who have been acutely ill, for a sufficient period of time to be sure that their restoration to health is complete, and that remote complications do not follow.

A HEALTH EXAMINATION

The following procedures can be effectively carried out by any doctor in his office, with the possible exception of the suggested x-ray examination:

PART I—THE HEALTH INVENTORY

A. The following questions are to be answered by the patient:

1. What physical complaint have you at this time?
2. When did you last consult a physician, and for what?
3. What is the usual state of your health?
4. Have you ever been rejected for life insurance?
5. Has any member of your family or household suffered from tuberculosis?
6. Have you ever had
   Tonsillitis?
   Scarlet Fever?
   Rheumatism?
   Venereal disease?
   Influenza?
   Spitting blood?
   Bleeding from any body outlets?
   Kidney or urinary disorder?
   (Females: State character of menstruation and any irregular discharges which you may have.)
7. Have you been vaccinated against
   Smallpox?
   Typhoid fever?
   Diphtheria?
8. State any serious illness you have had during your lifetime.

B. The doctor will make a physical examination of the patient, covering the following points:

1. Vision,—Acuity,—Eyegrounds.
2. Hearing. Inspection of auditory canals.
3. Nose and throat.
4. Tongue, Teeth, Gums and Mouth.
   (X-ray of teeth should be done if possible.)
5. Heart. Location of apex.
   Rate before exercise.....
   Rate after exercise.....
   Rhythm. Sounds.
   Blood pressure. Condition of vessels.
6. Lungs. Expansion.
   Auscultation.
   Percussion.
7. Abdomen. Organs. Hernia.
   Masses.
   Tenderness.
8. Nervous system. Reflexes.
9. Glandular system.
   Endocrine disorders.
10. Hemorrhoids. Rectum.
    Male: Prostate. Genital organs.
    Female: Perineum. Cervix. Pelvic organs.
11. Varicose veins. Feet. Edema of legs.
12. Joints. Spine.
    Pain or tenderness should be noted.

C. *Remarks*: Comments and explanations.

D. *Laboratory tests*:

1. Urinalysis:
   Reaction:
   Specific gravity:
   Color:
   Albumin:
   Sugar:
   Microscopic:
2. Blood:
   Hemoglobin:
   Blood Wassermann. Tests will be made by State laboratory.
3. X-ray.
   Fluoroscopy of chest.

(The incidence of pulmonary tuberculosis in the cross section of clerical groups among city people over twenty years of age is about ten per cent. In view of the fact that early symptoms are inconstant, chest x-ray study should be a part of every health review examination.)

PART II.

Based on the above examination, the Family Doctor will insist that all correctable defects shall be corrected; and will give advice concerning non-correctable defects.

PART III.

The Family Doctor will give prompt and early treatment in acute illness; suggest preventive processes such as immunization, desensitization, etc.; and advise restorative measures as indicated by signs of organic disability.

PART IV.

The Family Doctor will give advice regarding the correction of daily habits such as irregular bed-time; irregular eating hours; irregular time of bowel movement; eating hurriedly when over-tired; worry and mental stress; hours of work; recreation, and rest; and inadequate vacations. Watch out for fatigue which is not corrected by a night's rest.

PART V.

The Family Doctor will instruct patients who have been acutely ill to report at a definite time for a check regarding the degree of their recovery. Many people are suffering as the result of acute illness from which they have not fully recovered. The doctor should aim to prevent morbidity as painstakingly as he aims to prevent mortality.

Francis H. Glazebrook, *Chairman*
Theodore Teimer
Moses J. Fine

CHAPTER TWELVE

COMMUNICABLE DISEASES

J. Lynn Mahaffey, M.D., Director of Health of New Jersey

Protective Measures and Agencies.
The Family Doctor.
Department of Health.
Isolation of Cases.
Closing Schools.
Immunization.
Diphtheria,—Toxin, and Anti-Toxin.
The Public Health Hour.
Typhoid Fever,—Tracing the Origin of a Case, the Carrier.
Food Poisoning.
Streptococcus Infection.
Influenza, Colds.
The Pneumonias.
Meningeal Infections.
Rabies, Tetanus, Measles.

The modern practice of public health began in the decade 1880-1890, with the discovery of the specific microörganisms of the several communicable diseases, and their life histories; and the development of means for preventing their spread.

The hosts which harbor the organisms of a disease are either human beings, or lower animals. Most of the diseases which are public health problems in New Jersey are spread from *person* to *person*, either by direct contact with an infected person, or by means of an intermediate agent, such as mosquitos, or supplies of water or milk or other foods which are contaminated with the excretions of persons who have one of the diseases.

PROTECTIVE MEASURES

Five essential measures for the prevention of communicable diseases in New Jersey are:

1. The discovery and control of the persons who are carrying the germs in their bodies, many of whom are not aware of their condition.
2. Sanitary measures, including:

a. The disposal of the excretions of the human body.

b. The protection of food supplies, especially water and milk, from contamination with human waste products.

c. The treatment of public water supplies and the pasteurization of milk and milk products.

d. The destruction of insects, or animals, which are carriers of disease germs, including mosquitos, houseflies, and rats and mice, and other vermin.

3. The immunization of all persons, especially children, against certain diseases, particularly diphtheria and smallpox.
4. The practice of personal cleanliness by everybody.
5. Education of the public.

PROTECTIVE AGENCIES

The agencies which are directly responsible for the protection of the people against communicable diseases in New Jersey are:

1. The medical profession.
2. Public Health officials.

Others who play important parts in this field include:

a. Public school officials.

b. Voluntary health agencies and welfare workers.

c. Each individual citizen.

THE FAMILY DOCTOR

The Family Doctor is the key man in every system for protecting the people against communicable diseases. His responsibility is twofold:

1. Personally, to his patients and their immediate families; and officially to Boards of Health.
2. Collectively, through his County Medical Society, to public officials, and to the citizens generally.

No individual physician can control all the health menaces in his community; nevertheless

every Family Doctor has a personal responsibility to give his active support to measures which must be carried out by local health authorities and the leaders in civic organizations.

THE DEPARTMENT OF HEALTH

Every Family Doctor has the status of an unofficial *health officer* who is charged with certain public duties, including:

1. Reporting every case on the list of communicable diseases which have been made reportable by the laws of the State of New Jersey, and the regulations of the State Department of Health and the health authorities of his local community. The Family Doctor is required by the laws of New Jersey to report every case of the following diseases to his local Department of Health:

Anthrax
Chickenpox
Cholera, Asiatic
Diphtheria (membranous croup)
Dysentery, amoebic and bacillary
Encephalitis, lethargic
Glanders
Influenza
Leprosy
Malaria
Measles
Measles, German (Rubella)
Meningitis, epidemic cerebrospinal
Mumps
Ophthalmia neonatorum
Paratyphoid fever
Pneumonia (broncho, lobar)
Plague
Poliomyelitis, acute anterior (infantile paralysis)
Rabies (hydrophobia)
Scarlet fever
Smallpox (varioloid)
Tetanus
Trachoma
Trichinosis
Tuberculosis, all forms
Tularemia
Typhoid fever
Typhus fever (Brill's disease)
Undulant fever
Whooping cough
Yellow fever

(Other diseases may also be required to be reported locally by ordinance of a local board of health.)

2. Advising members of the families of his patients who have a reportable disease regarding the measures which are necessary for preventing the spread of the disease among themselves and to other persons.

3. Informing the local health officer regarding the failure of any person to carry out the directions which he advises.

As an unofficial health officer, the Family Doctor has performed his *legal* duties when he has made a conscientious effort to conform to the requirements of the law. But he still is under the *moral* obligation to uphold the efforts of the Department of Health to carry out the necessary protective measures.

The three principal means of protection against the prevailing communicable diseases in New Jersey are:

1. The *isolation* of patients and the carriers of disease germs, and of contacts with cases of certain diseases.
2. *Immunization* of susceptible individuals.
3. The *treatment* of infected persons.

ISOLATION OF CASES

The *quarantine,* or its modern development—*isolation*—still is necessary for protecting the public against those communicable diseases which are spread through the contact of the affected person with his fellows in the ordinary contacts of life.

Any one of these diseases may exist in a form so mild that the affected person or his family may deny its existence, and may refuse to conform to the isolation which is imposed. The most difficult problem in public health which confronts the Family Doctor and the health officer is that of enforcing the principle of isolation upon these mild cases. The ultimate recourse of the health authorities is to the courts.

In two of the common reportable diseases,—diphtheria and typhoid fever,—the discovery of the specific microörganisms of the disease in the excretions of the patient is generally possible; and in the presence of this positive evidence, the courts and public opinion support the imposition of preventive measures on the affected persons. The Family Doctor is the *key man* in securing the *voluntary* conformity of cases and carriers to the principle of isolation.

CLOSING SCHOOLS

The Family Doctor, the health officer and the Board of Education are often confronted with the popular demand to promote the isolation of children from one another by closing a school on the outbreak of a number of cases of communicable disease among the pupils. In this situation, a more effective procedure is usually the following:

1. Keep the school open, but do not invoke the services of the attendance officer to compel any child to come to school.

2. Account for the health of every pupil by two measures:

a. The personal inspection and observation of every child who is *present* in school.

b. Secure information regarding every *absent* pupil by means of a telephone message to the parents, or a personal visit by the nurse, or by communicating with the Family Doctor of the child.

The principles on which these measures are founded are these:

1. The teacher, or school nurse, or the medical inspector is a close observer of each pupil, and is quick to note any departure from his normal appearance and behavior, such as a flushed face, red eyes, or a listless attitude. On such findings, the child should be sent home with a note to the parents to observe the child for definite signs of prevailing communicable disease, and to call the Family Doctor.

2. A child behaves and observes discipline in school better than in any other place; and is therefore less likely to spread his disease than when he is in the streets uncontrolled.

3. Parents and their Family Doctor appreciate the system which leads to the detection of cases of communicable diseases which would otherwise go unrecognized.

4. The cost of the preventive measures is less than the expense of keeping the school open later in the year in order to make up for the time lost by the closure of the schools.

IMMUNIZATION

The second public health measure which can be applied widely in New Jersey against communicable diseases is that of immunizing individuals against a disease.

Vaccination against smallpox was first publicly announced in 1798, and since that time it has been generally applied among all civilized people, and has almost completely eradicated the disease in New Jersey so that most physicians of the State have never seen a case of the disease which was formerly one of the most common of all prevailing diseases. However, every case of smallpox is still extremely contagious, and vaccination remains the only effective measure for protecting the people against it.

The only valid objection against vaccination, —that of sore arms,—has been completely met by two measures:

1. The use of a pure vaccine in which pathogenic germs are absent.

2. The aseptic method of vaccination by which pathogenic germs from extraneous sources are excluded.

DIPHTHERIA ANTITOXIN

The discovery of antitoxin in 1895, followed by the development of scientific methods of standardizing its production and application, have led to its universal adoption for treating cases of diphtheria with success, and have reduced the mortality from the disease to an extremely low rate.

A second milestone of progress in the control of diphtheria was passed when the method of detecting diphtheria in its earliest stages by means of cultures was standardized, and made available to every Family Doctor through the services of the Laboratory of the State Department of Health. Every Family Doctor now recognizes his duty to take a culture of the throat of every suspicious case at his first call, and to mail it to the Laboratory; and if the symptoms warrant it, to give an injection of antitoxin.

A third milestone was the discovery of a safe, efficient method of producing immunization by injecting a small amount of diphtheria toxin-antitoxin, or its modern substitute, *toxoid,* subcutaneously.

A fourth milestone of progress in the eradication of diphtheria was the discovery of the *Schick test* for detecting those children who are susceptible to diphtheria. This consists in the injection of a minute amount of standardized diphtheria toxin into the skin of the arm. A red spot developing at the site of the injection of the toxin indicates a lack of immunity; and therefore the need of being immunized.

A fifth milestone was reached when Departments of Health and Education, Parent-Teacher Associations, and Public Health Nursing organizations promoted clinics in the schools for applying the Schick test to all school children, and immunizing those who were found susceptible to diphtheria.

The general promotion of the clinics has resulted in the reduction of diphtheria among children of the school age and older persons to an extremely low rate. However, diphtheria still remains a public menace to children, particularly to those below the school age; and a large proportion of the deaths that occur are among children who have not reached the school age. Efforts to meet this situation have included "Summer round-ups" of the older children of the pre-school age.

A sixth milestone in the prevention of diphtheria was the promotion of the plan that every physician, especially those doing a general practice, should approach the parents on his calling list, and induce them to bring their children to his office to be immunized. This plan was in two parts:

1. The physician should immunize his ordinary pay patients during his regular office hours.

2. The physician should set aside a "Public Health Hour", when he would immunize children at a reduced rate, with the State Department of Health coöperating by supplying the immunizing material free. The Public Health Hour also includes smallpox vaccination.

The results of the operation of the plan have been reported in each issue of The Journal during the past two years; but they have not been entirely satisfactory for the reasons which are indicated in the chart 15, which is republished

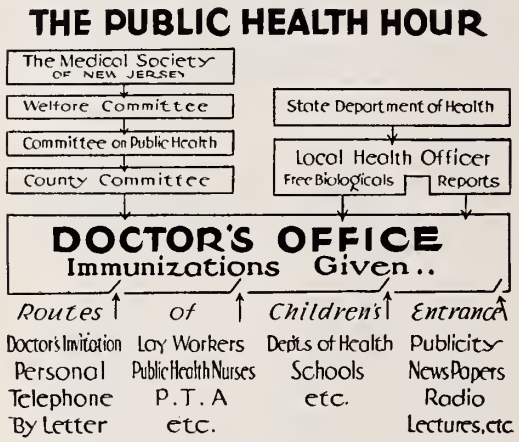


Chart 15.—The Public Health Hour, and the four avenues of approach to it.

from The Journal of October, 1935, page 614. The chart shows that there are four avenues (or doors) of approach to the doctor's office during his Public Health Hour:

1. His own solicitation of parents on his calling list, and the display of a sign supplied by The Medical Society of New Jersey, indicating the day and hour when he would give the immunizations under the plan of the Public Health Hour.

2. Voluntary organizations, especially Parent-Teacher Associations and Public Health Nursing organizations.

3. The State Department of Health, and local departments and health officers.

4. Publicity through newspapers, radio talks, and popular lectures.

Experience has demonstrated the following facts:

1. Physicians have responded well.

2. The State Department of Health has done its part, as have most local Health Departments whose facilities permit.

3. A more active coöperation by all health agencies is necessary in order to influence individual parents to take their children to the office of the Family Doctor to receive the immunization.

It is therefore necessary that every county medical society should take steps to enlist the active coöperation of health organizations in sending or taking the children to the doctors' offices instead of emphasizing public clinics for immunizations. However, clinics still seem to be necessary in order to get immediate results on a large scale and to reach those who do not go to doctors' offices for immunization.

GASTRO-INTESTINAL INFECTIONS

Gastro-intestinal diseases are spread by food and water contaminated with the excretions from diseased persons or carriers, or in a few disorders, from a lower animal, such as a mouse that has mouse typhoid.

TYPHOID FEVER

Typhoid fever is a typical water-borne and food-borne infection, now happily uncommon because of the efficient disposal of sewage, and the protection and purification of public water supplies and the pasteurization of milk; and also the discovery and control of cases early in the disease and the identification of carriers.

Widal Test. A Family Doctor who is called to a case that is suspicious of typhoid fever will take a drop of the patient's blood, dry it on a metal plate furnished by the State Department of Health, and send it to the Laboratory of the Department for an agglutination reaction with a pure culture of typhoid bacilli. If the report is negative, another specimen should be sent after a few days, for the body requires a few days to form agglutinins which produce the reaction. Outfits for taking and mailing the specimens are supplied free to physicians by the State Department of Health.

Preventive Measures. An early diagnosis enables the Family Doctor to give advice regarding precautions against the spread of the disease, including the following points:

1. The isolation of the patient from direct contact with other members of the family and visitors.

2. The nurse or attendant is to wash her hands in an antiseptic at once after coming in contact with the patient or his discharges; and to sterilize the soiled dishes and bedclothing at once in boiling water.

3. To dispose of all excretions either in a safe sewer system, or a closed cesspool, or by burial.

4. The Family Doctor will also give preventive inoculations to the nurse and all members of the family.

5. The Family Doctor will also advise the

general use of the inoculations during an outbreak; and to persons who are expecting to camp or travel.

The Family Doctor is required to report to the local Department of Health every case of typhoid which he treats.

DATE OF ONSET

In investigating the source of infection of a case of typhoid fever, the first item of information to be obtained is the date of onset of the *first symptoms.* The Family Doctor is likely to give the date of his *first visit* as the date of onset; but very likely the patient has had vague abdominal and general symptoms for a week or two. The Family Doctor will coöperate with the health officer in patiently questioning the patient regarding the events of his daily life; and finally the patient will probably recall an afternoon when he went home early because of a tired feeling and abdominal pain which became steadily worse day by day. The date of the first noticeable weariness or pain is the probable date of onset of the disease.

DATE OF INFECTION

The second date to be determined is that of *infection,* which will be from ten to twenty days before the date of onset, for about that period of time is required for the germs to multiply in the body in sufficient quantity to produce the disease.

The patient's recollection of the events of his life during a month before the onset of the disease is likely to be even more vague than his memory of what occurred at the date of the onset of his sickness.

The Family Doctor cannot be expected to conduct an investigation into all the places which the patient had visited during the period when he had acquired his infection; but as far as practical the health officer will do so carefully and thoroughly, and with the support of the Family Doctor.

TYPHOID CARRIERS

Some patients continue to excrete typhoid bacilli for months and years after their apparent recovery. It is a requirement of the Sanitary Code of New Jersey that two negative cultures of the stools and urine be obtained at intervals of one week before the patient is discharged from observation and control.

How to control a chronic typhoid carrier is one of the most exasperating problems that confront a Family Doctor and health officer. The gall-bladder is sometimes a reservoir of the germs, and its removal may cure the carrier condition.

The two most practical requirements regarding a chronic typhoid carrier are:

1. He shall be excluded from all occupations requiring the handling of milk or other foods.
2. He shall observe strict personal cleanliness after urination and defecation.

TOXIN POISONING

Food or water containing toxins may produce severe gastro-intestinal symptoms. One cause of food infections is mice or rats that are affected with *rodent typhoid.* The virus grows rapidly, and in a night it may produce enough toxin to cause a severe diarrhoea in those who eat the contaminated food.

Characteristics of an outbreak caused by toxins in food are:

1. The sudden onset of the symptoms—four to twenty-four hours.
2. The use of food or water from a common source by all the patients.
3. The rapid recovery of the patients when the toxins are expelled from the intestine.
4. The rapid subsidence of the outbreak.

When the Family Doctor is confronted with a sudden outbreak of gastro-intestinal infections, he will take the following steps promptly:

1. Report his cases to the health officer, and his suspicions regarding their cause and origin.
2. Assist the health officer in tracing the outbreak to its source and in discovering mild cases.
3. Inform his families of the nature of the outbreak, and the precautions which they should take to avoid its repetition.

STREPTOCOCCUS INFECTIONS

There is a series of throat infections with streptococci which may spread to the nose and the middle ears, to the bronchi and lungs, to the blood stream and heart, and to the serous membranes of the joints. They are present in *scarlet fever,* and are the cause of *erysipelas,* and *septic sore throat,* and of serious forms of wound infections.

Streptococci grow readily on culture media containing hemoglobin, and are divided into two classes,—the *viridans* whose colonies are green; and the *hemolytic,*—the more virulent form,—whose colonies hemolyze the medium.

One form of streptococcus infection is that which is carried by milk contaminated from infected milkers, either by transfer directly to the milk, or after an intermediate lodgement and growth in the cow's udder.

The usual form of a milk-borne strepto-

coccus infection is a sore throat and tonsillitis; but it may invade any part of the body. Both streptococcus sore throat and scarlet fever are caused by the hemolytic form of streptococci, which may be recognized on a culture. They sometimes form a membrane in the throat, like that of diphtheria. It is therefore important that a culture be taken when a diagnosis is in doubt.

Scarlet fever may exist with little or no discernable eruption.

The Dick skin test, which is similar to that of the Schick test in diphtheria, is of value in determining the susceptibility of a patient to scarlet fever.

The Family Doctor. From a public health point of view, the Family Doctor treating a patient with sore throat has definite responsibilities in preventive medicine, some of which are as follows:

1. Make a diagnosis, taking cultures if necessary.
2. Separate the patient from other people, and dispose of his excretions in a safe way.
3. Advise the patient of the danger of handling food or milk.
4. If there is an outbreak of any form of streptococcus infection, report the cases to the health officer, and assist him to trace the sources of the cases.

INFLUENZA AND COLDS

Influenza is probably the most difficult of all common diseases to control, for three reasons:

1. Its period of incubation is very short—only a day or two; and so a whole series of patients may infect one another before the disease is diagnosed.
2. The early symptoms of the disease are often those of a severe form of a common cold.
3. It is extremely infectious, especially during its early stages, partly because of the virulent nature of the infection, and partly because it causes sneezing and coughing, thereby spreading the infection for several feet around the patient.

The cause of neither influenza nor a common cold has yet been determined with certainty, although the evidence seems to be that each is caused by a virus.

The opportunity to act as the friendly health officer devolves upon the Family Doctor whenever he is called to treat a patient for a "cold" or influenza. His public duty is then twofold:

1. To make a correct diagnosis,—which may require several days.
2. To advise the family regarding isolation and other measures for preventing the disease —whatever it may turn out to be—from spreading to other members of the family, or to the neighbors.
3. To report cases of influenza to the health officer.

THE PNEUMONIAS

It is proper to use the plural number in speaking of pneumonia, for it is produced by a number of organisms besides the pneumococcus; and also there are many strains of pneumococci, varying in virulence and in their capacity to arouse the body to form antibodies. Therapeutic sera for some forms of pneumococci are available and are potent if they are used early in the disease, and if the proper variety is chosen. Rapid methods of typing pneumococci are now available, so that the type in a favorable specimen of sputum may be determined in an hour. About twelve hours are required in unfavorable specimens,—a period which may be within the span of effectiveness of the proper serum.

The laboratory of the State Department of Health is prepared to examine specimens of sputum for the type of infection. Typing of pneumococci is also made in some hospital and municipal laboratories.

The expectorated material should come from the lungs and be as free from saliva and nasal secretions as possible.

The specimen of sputum should be collected in a clean, wide-mouth bottle free from any preservative and sent without delay by messenger to the nearest laboratory making such examinations.

Knowing the type of pneumococcus, the appropriate serum may be purchased from a biological supply house.

A Family Doctor, treating a patient with pneumonia, has certain public health functions:

1. To inform the family of the communicable nature of the disease, and the precautions for preventing its spread to other members of the household.
2. To report the case to the health officer.

MENINGEAL INFECTIONS

The meninges of the central nervous system may be infected with streptococci, pneumococci, the tubercle bacilli, and other microorganisms, but the most common infective agent is the *meningococcus* of which there are several types. Each of the types will produce an antibody. The serum that is usually put up by manufacturers consists of a mixture of serum for two or more common types of meningococci.

The physician will have a spinal tap made for diagnostic purposes if necessary, and will give the proper serum as early as possible.

The public health functions of a Family Doctor in regard to cerebro-spinal meningitis are:

1. Inform the family of the precautions to take against spreading the disease.
2. Report the case to the health officer.

RABIES

When the Family Doctor is called to a person who has been bitten by a dog or cat, he will adopt the following course of action:

1. Report the name and address of the person bitten to the local board of health.
2. Obtain a history of the animal and its actions both before and after the bite.
3. If there is reason to suspect that the animal was rabid, treat the wound of the person with nitric acid applied down to its deepest part in order to destroy the virus of rabies, if any is present.
4. Give a course of anti-rabic injections even if the diagnosis is only suspicious, and do not wait for a positive diagnosis.

The Animal.—If the animal is well, or only slightly sick, do not kill it, but securely confine it in a safe place. If it has rabies, it will become evidently sick within a few days. It can then be killed and a definite diagnosis made by an examination of its brain.

When the animal is dead, the Family Doctor will direct that its head be removed and placed in a pail of ice and sent to the Laboratory of the Department of Health, where the Laboratory will examine the brain microscopically for Negri bodies, whose presence indicates rabies.

Rabies is a public health emergency which justifies sending the head to the laboratory promptly by special messenger.

If a diagnosis of rabies in the animal is made, the Family Doctor will give exposed persons a series of preventive inoculations in order to produce immunity to the rabies virus which may be in the body.

TETANUS

The bacilli of *tetanus,* or *lockjaw,* are anerobic, and are likely to grow when they are introduced deep into the flesh, as by a wound made by a deep puncture or by crushing. Preventive measures against tetanus are:

1. Treat the wound according to surgical principles.
2. Give a preventive injection of tetanus antitoxin.

MEASLES

Measles is extremely contagious; and nearly every child catches it. The deaths are most likely to be among children of the pre-school age. A preventive injection of immune serum from a recently recovered case may prevent the development of the disease.

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State House, Trenton, N. J.
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Supplement to The Journal of The Medical Society of New Jersey, April, 1937

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FOR THE YEAR 1937

THE NEW JERSEY MEDICINE
APR 20 1937
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*Hezekiah Stites 1775

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WELLS P. EAGLETON (1937) ..... Newark
WILLIAM J. SWEENEY (1938) ..... Weehawken
ALFRED STAHL (1940) ..... Newark
ANDREW F. MCBRIDE (1941) ..... Paterson
ELIAS J. MARSH, Ex-Officio ..... Paterson

Honorary Membership

LANCELOT ELY, *Chairman* (1938) ..... Somerville
FREDERIC J. QUIGLEY (1937) ..... Union City
EPHRAIM R. MULFORD (1939) ..... Burlington

Hospitals and Medical Education

HARRY H. SATCHWELL, *Chairman* ..... Newark
STUART ZEH HAWKES ..... Newark
ARCANGELO LIVA ..... Hackensack
DAN S. RENNER ..... Skillman
DAVID F. BENTLEY, JR. ..... Camden

Medical Defense

CHRISTOPHER C. BELING, *Chairman* ..... Newark
EDGAR A. ILL ..... Newark
CHARLES F. BAKER ..... Newark
WILLIAM J. ARLITZ ..... Hoboken
LEROY W. BLACK ..... Rutherford

Insurance

FRANK W. PINNEO, *Chairman* ..... Newark
JOSEPH W. HURFF ..... Newark
EDMUND N. HUFF ..... Englewood
THOMAS J. SUMMEY ..... Moorestown
LAWRENCE H. BLOOM ..... Phillipsburg
IRVING OKIN ..... Passaic
ALBERT J. WARD ..... Morristown

WELFARE COMMITTEE

Hilton S. Read, *Chairman*, Atlantic City

Spencer T. Snedecor, Ex-Officio ..... Hackensack
I. Bennett Morrison, Ex-Officio ..... Newark
Hugo Alexander ..... Hoboken
Samuel Alexander ..... Park Ridge
William H. Areson ..... Upper Montclair
Frank Ash ..... Paterson
Arthur W. Bingham ..... East Orange
E. P. Cardwell ..... Newark
John G. Clayton ..... Freehold
A. H. Coleman ..... Clinton
William F. Costello ..... Dover
George F. Dandois ..... Wildwood
S. B. English ..... Glen Gardner
Frank L. Field ..... Far Hills
J. Irving Fort ..... Newark
David W. Green ..... Salem
D. Leo Haggerty ..... Trenton
Henry Haywood ..... New Brunswick
Eugene G. Herbener ..... Lakewood
Ernest G. Hummel ..... Camden
A. G. Ireland ..... Trenton
J. H. Irwin ..... Englewood
J. H. Kler ..... New Brunswick
I. Warner Knight ..... Pitman
Thomas K. Lewis ..... Camden
Julius Levy ..... Newark
Wright MacMillan ..... Passaic
Jacob J. Mann ..... Perth Amboy
Charles H. Mitchell ..... Trenton
Stanley Nichols ..... Asbury Park
Herschel Murphy ..... Roselle
Henry B. Orton ..... Newark
James S. Plant ..... Newark
B. S. Pollak ..... Jersey City
Louis A. Pyle ..... Jersey City
D. Ward Scanlan ..... Atlantic City
Charles H. Schlichter ..... Elizabeth
T. J. Schuck ..... Hoboken
Millard F. Sewall ..... Bridgeton
R. L. Sharp ..... Camden
Byron G. Sherman ..... Morristown
C. H. deT. Shivers ..... Atlantic City
James H. Spencer ..... Franklin
Samuel Emlen Stokes ..... Moorestown
R. G. Stone ..... Trenton
Theodor Teimer ..... Newark
Chester I. Ulmer ..... Gibbstown
W. H. Varney ..... Washington
Elmer P. Weigel ..... Plainfield
H. B. Wilson ..... Hackensack
A. Charles Zehnder ..... Newark

SUB-COMMITTEES OF THE WELFARE COMMITTEE

Public Health

Stanley Nichols, *Chairman* ..... Asbury Park
Theodor Teimer ..... Newark
Julius Levy ..... Newark
Allen G. Ireland ..... Trenton
Ernest G. Hummel ..... Camden
I. W. Knight ..... Pitman
A. E. Jaffin ..... Jersey City

Medical Practice

Thomas K. Lewis, *Chairman* ..... Camden
J. Irving Fort ..... Newark
Chester I. Ulmer ..... Gibbstown
D. Leo Haggerty ..... Trenton
Louis A. Pyle ..... Jersey City

Legislation

B. S. Pollak, *Chairman* ..... Jersey City
Samuel Alexander ..... Park Ridge
William H. Areson ..... Upper Montclair
William Costello ..... Dover
Charles H. Mitchell ..... Trenton

Public Relations

J. H. Kler, *Chairman* ..... New Brunswick
Hilton S. Read ..... Atlantic City
S. Emlen Stokes ..... Moorestown
E. P. Cardwell ..... Newark
Wright MacMillan ..... Passaic

ADVISORY COMMITTEES TO PUBLIC HEALTH SUB-COMMITTEE

Cancer Control

Henry B. Orton, *Chairman* ..... Newark
F. C. McCormack ..... Englewood
James H. Rosecrans ..... Hoboken
John F. Condon ..... Newark
Carl Menge ..... Toms River
J. H. Kler ..... New Brunswick
E. E. Downs ..... Woodbury

Maternal Welfare

Arthur W. Bingham, *Chairman* ..... East Orange
J. Carlisle Brown ..... Atlantic City
P. DuBois Bunting ..... Elizabeth
Samuel A. Cosgrove ..... Jersey City
F. D. Fahrenbruch ..... Mount Holly
Carl H. Ill ..... Newark
R. A. MacKenzie ..... Asbury Park
Walter B. Mount ..... Montclair
Theodore F. Thompson ..... Lakewood
H. B. Wilson ..... Hackensack

Venereal Disease Control

C. H. deT. Shivers, *Chairman* ..... Atlantic City
Stanley R. Woodruff ..... Jersey City
Clarence O'Crowley ..... Newark
C. Byron Blaisdell ..... Long Branch
George N. J. Sommer ..... Trenton
A. Haines Lippincott ..... Camden

Mental Hygiene

James S. Plant, *Chairman* ..... Newark
Dan S. Renner ..... Skillman
Marcus A. Curry ..... Greystone Park
J. B. Gordon ..... Marlboro
Matthew Molitch ..... Jamesburg
George S. Stevenson ..... Red Bank

Tuberculosis

B. S. Pollak, *Chairman* ..... Jersey City
Samuel B. English ..... Glen Gardner
J. R. Morrow ..... Oradell
Frederic W. Lathrop ..... Plainfield
J. F. Pessel ..... Trenton
George M. Levitas ..... Westwood

Child Health

Stanley Nichols, *Chairman* ..... Asbury Park
Ernest G. Hummel ..... Camden
Walter B. Stewart ..... Atlantic City
L. Charles Rosenberg ..... Newark
Victor A. Blenkle ..... Teaneck

Crippled Children

Elmer P. Weigel, *Chairman* ..... Plainfield
F. G. Dilger ..... Hackensack
David B. Allman ..... Atlantic City
Thomas K. Lewis ..... Camden
B. Moffat ..... Red Bank
F. H. Pinckney ..... Morristown

ADVISORY COMMITTEES TO MEDICAL PRACTICE SUB-COMMITTEE

Contract Practice

R. L. SHARP, *Chairman* ..... Camden
EDWARD F. KLEIN ..... Perth Amboy
L. SAMUEL SICA ..... Trenton
JOSEPH A. VISCONTI ..... Hoboken
L. A. MARKLEY ..... Teaneck
HARVEY T. HEROLD ..... Newark

Hospital Relationships

THOMAS K. LEWIS, *Chairman* ..... Camden
EDWARD W. SPRAGUE ..... Newark
RAYMOND J. MULLIN ..... Newark
RUSSELL K. TETHER ..... Closter
FLORENTINE HOFFMAN ..... New Brunswick
E. W. LANCE ..... Rahway
CHARLES B. KELLEY ..... Jersey City
HENRY B. DECKER ..... Camden

Medical Care of Indigent

CHARLES H. SCHLICHTER, *Chairman* ..... Elizabeth
GEORGE W. FITHIAN ..... Perth Amboy
*A. HAINES LIPPINCOTT ..... Camden
J. HOWARD HORNBERGER ..... Roebling
FRED VOSBURGH ..... Passaic
*Died March 10, 1937.

Nursing and Nursing Education

A. CHARLES ZEHNDER, *Chairman* ..... Newark
HARRY H. SATCHWELL ..... Newark
GEORGE M. KNOWLES ..... Hackensack
I. F. FROST ..... Morristown
DAVID B. ALLMAN ..... Atlantic City
H. WESLEY JACK ..... Camden
EDGAR A. ILL ..... Newark

Pharmaceutical Problems

CHESTER I. ULMER, *Chairman* ..... Gibbstown
MERWIN L. HUMMEL ..... Merchantville
SAMUEL BARBASH ..... Atlantic City
ALVIN E. KUHLMANN ..... Union City
SIGURD W. JOHNSEN ..... Passaic

Workmen's Compensation

J. IRVING FORT, *Chairman* ..... Newark
DAVID A. KRAKER ..... Newark
GEORGE W. FINKE ..... Hackensack
V. EARL JOHNSON ..... Atlantic City
JOHN F. MCGOVERN ..... New Brunswick

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WAYNE W. HALL ..... Paterson
JOSEPH M. KUDER ..... Mount Holly
H. H. TYNDALL ..... Weehawken
CHARLES BAILEY ..... Lakewood

Woman's Auxiliary

H. ROY VAN NESS, *Chairman* ..... Newark
A. E. JAFFIN ..... Jersey City
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ELWOOD E. DOWNS ..... Woodbury
JOHN W. GRAY ..... Newark
ROBERT A. KILDUFFE ..... Ventnor
WILLIAM J. MARQUIS ..... Newark
HARRISON S. MARTLAND ..... Newark
CARLOS A. PONS ..... Asbury Park
HARRY J. PERLBERG ..... Jersey City

The Department of Health of the State of New Jersey

J. LYNN MAHAFFEY, M.D., *Director of Health*
State House, Trenton, N. J.
Room 232, Tel. Trenton 2-2131, Ext. 266

State Board of Medical Examiners of New Jersey

JAMES J. MCGUIRE, M.D., *Secretary*
Trenton Trust Bldg., 28 W. State St., Trenton, N. J.
Room 1101, Tel. Trenton 2-2131, Ext. 272

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First Vice-President, MRS. H. D. CORBUSIER ..... Plainfield
Second Vice-President, MRS. G. E. MCDONNELL ..... Mt. Holly
Third Vice-President, MRS. WILLIAM FREILE ..... Jersey City
Recording Secretary, MRS. DAN S. RENNER ..... Skillman
Treasurer, MRS. T. P. MCCONAGHY ..... Camden

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County	President	Secretary	Reporter
ATLANTIC	John S. Irvin, Atlantic City.....	J. Carlisle Brown, Atlantic City..	E. H. Nickman, Atlantic City
BERGEN	John H. Irwin, Englewood	George M. Knowles, Hackensack..	LeRoy W. Black, Rutherford
BURLINGTON..	E. Lester Small, Medford	E. Warren Rodman, Beverly.....	Parry M. Scott, Beverly
CAMDEN	B. F. Buzby, Camden	R. S. Gamon, Camden	Harold D. Barnshaw, Camden
CAPE MAY	John B. Townsend, Ocean City...	Warren D. Robbins, Cape May...	Warren D. Robbins, Cape May
CUMBERLAND .	H. Burton Walker, Vineland	H. S. Branin, Millville	E. S. Corson, Bridgeton
ESSEX	Edgar A. Ill, Newark	Frank W. Pinneo, Newark	E. LeRoy Wood, Newark
GLOUCESTER..	M. F. Lummis, Pitman	E. E. Downs, Woodbury	Henry B. Diverty, Woodbury
HUDSON	J. Lawrence Evans, Woodcliff....	Thos. McG. Brennock, Jersey City	John N. Connell, Jersey City
HUNTERDON ..	E. W. Lane, Bloomsbury	A. L. Gramsch, Glen Gardner....	A. L. Gramsch, Glen Gardner
MERCER	Walter E. D'Arcy, Trenton	A. D. Hutchinson, Trenton	A. D. Hutchinson, Trenton
MIDDLESEX ..	John H. Rowland, New Brunswick	J. F. Sandella, New Brunswick...	Charles Calvin, Perth Amboy
MONMOUTH ..	Walter A. Rullman, Red Bank...	Dan'l F. Featherston, Asbury Park	O. R. Holters, Asbury Park
MORRIS	Byron G. Sherman, Morristown...	George J. Young, Morristown.....	Marcus A. Curry, Greystone P'k
OCEAN	Robert Buermann, Lakewood	Emanuel Sickel, Lakewood	Robt. McC. Halbach, Toms River
PASSAIC	Norman M. Dingman, Paterson...	Wayne W. Hall, Paterson	Sigurd W. Johnsen, Passaic
SALEM	J. S. Dunn, Salem	David W. Green, Salem	L. C. Hummel, Salem
SOMERSET	W. B. Gray, North Plainfield.....	L. C. Fritts, Somerville	A. W. Pigott, Skillman
SUSSEX	Warren Smith, Newton	Leo Drake, Franklin	G. H. Groeschel, Sussex
UNION	Elmer P. Weigel, Plainfield	Lorrimer B. Armstrong, Westfield.	Cedric C. Carpenter, Summit
WARREN	William Varney, Washington.....	William F. Skinner, Washington..	H. B. Bossard, Phillipsburg

The Secretary of the Component Society should promptly notify the Recording Secretary of The Medical Society of New Jersey and the Editor of the Journal of any error or change in these offices.

DELEGATES TO THE MEDICAL SOCIETY OF NEW JERSEY
1937

ATLANTIC COUNTY

Delegates	Alternates
Allman, David B.	Blampin, Winifred A.
Charlton, C. Coulter	Durham, Royal E.
Darnall, Wm. E.	Boysen, Theophilus H.
Harvey, Edwin H.	Whims, Clarence B.
Salasin, Samuel L.	Subin, Harry
Scanlan, D. Ward	Mason, James H.
Shivers, Chas. H. deT.	Hyman, Chas.
Read, Hilton S.	Stewart, Walter B.

BERGEN COUNTY

Wilson, H. B.	Farmer, Vincent
Hallett, Fred'k S.	Vandersluis, Harold H.
Finke, Geo. W.	Edwards, J. Bennett
Levitas, Geo. M.	Irwin, John H.
Littwin, Chas.	Tether, Russell K.
Corn, David	Duisberg, E. H.
King, Chester A.	Hull, Donald B.
Dezer, Chas. N.	Markley, Luther A.
Essertier, Edward P.	Dilger, Fred'k G.
Black, LeRoy B.	Farr, Walter
Morrow, Jos. R.	Sarla, M. A.
Liva, Arcangelo	Seymour, Edward T.
Huff, Edmund N.	Hitzemann, Louis A.
Vroom, Wm.	Blenkle, Victor A.
Knowles, Geo. M.	Burnham, Lyman

BURLINGTON COUNTY

Hornberger, J. Howard	Kuder, Jos. M.
Stokes, S. Emlen	Scott, Parry M.
Haines, Edgar J.	Hartman, Luther
Darlington, Emlen P.	Peacock, Arthur B.

CAMDEN COUNTY

Hollinshed, Beulah	Fisher, Stella
Hummel, Ernest G.	Meyer, Geo. P.
Lee, Thomas B.	Wilson, L. R.
Hutcheson, Chas. R.	McCarthy, Arthur M.
Jack, H. Wesley	Hessert, Edmund C.
Schrack, Helen F.	Glover, Lawrence
Shipman, James S.	Barnshaw, Harold D.
Roberts, Jos. E.	West, Gordon F.
Kline, Oram R.	Shull, Elliott C.
Howard, J. Edgar	Mengel, G. Willard
Sharp, Reuben L.	Del Duca, Vincent

CAPE MAY COUNTY

Dandois, Geo. F.	Hughes, Frank R.
Way, Clarence W.	Ziegler, Oscar F.
Pettit, Herschel	Townsend, John B.

CUMBERLAND COUNTY

Walker, H. Burton	Van Deusen, Edwin B.
Miller, Harry G.	Branin, Howard S.
Myatt, Leslie E.	Carson, Elton S.
Lyon, Earl C.	Ware, Carl

ESSEX COUNTY

Blackburne, Geo.	Antonius, N. A.
Crecca, D. Wm.	Coburn, John W.
Danzis, Max	Farr, Irving L.
Freeman, Richard D.	Harvey, Thos. W., Jr.
Hurff, J. Wallace	Levy, Julius
Ill, Edgar A.	Mancusi-Ungaro, L.
McCauley, Francis J.	Marquis, Dean
Orton, Henry B.	Minard, E. L.
Pinneo, Frank W.	Parsonnet, Eugene
Ranson, B. B., Jr.	Robbins, Chas. M.

ESSEX COUNTY—Continued

Delegates	Alternates
Reissmann, Erwin	Seigel, Jos. W.
Steiner, Edwin	Toye, John E.
Tansey, Wm. A.	Tutschulte, Ernest
Tarbell, Harold A.	Warner, W. H. A.
Van Ness, H. Roy	Allan, James S.
Zehnder, A. Chas.	Broadnax, Mary
Bingham, Arthur W.	Echikson, Jos. I.
Bradshaw, John H.	Emerson, Linn
Carbone, Francis N.	Flynn, Edward A.
Comando, Harry N.	Harden, Albert S.
Condon, John F.	Ill, Herbert M.
Cook, Hugh F.	Kessler, Henry H.
Hawkes, E. Zeh	Moore, John D.
Ill, Chas. L.	Muta, S. A.
Martland, Harrison S.	Schaaf, Royal A.
Mitchell, August J.	Smith, Ellis L.
Snavely, Earl H.	Voorhees, Florence
Sprague, Edward W.	Barkhorn, Chas. W.
Teimer, Theodor	Baldwin, Samuel H.
Wallhauser, Henry J.	Blanchard, Kenneth
Wherry, Elmer G.	Braun, Gustave
Areson, W. H.	Carman, Fletcher F.
Connolly, Richard N.	Chamberlain, A. R.
Epstein, Harry B.	Crane, Chas. G.
Fort, J. Irving	Erler, Eugene W.
Grady, Wm. F.	Ganley, A. J.
Gray, John W.	Godfrey, Alan O.
Hosp, Paul H.	Gutowski, W. T.
Keller, Sidney C.	Klein, E. C., Jr.
Kraker, David A.	Matheke, Otto G.
Lowrey, James H.	Murray, Harold A.
Menk, Paul E.	Parisi, Anthony
Mount, Walter B.	Sherman, A. Russell
Mullin, Raymond J.	Satchwell, H. H.
Pilch, Arthur	Walton, R. W.
Rathgeber, C. F.	Wyker, Arthur W.
Rich, Chas.	Forsythe, K. C.
Stahl, Alfred	Gregory, M.
Weber, Francis C.	Herold, H.
Wood, Earl L.	Schneider, L. A.
Barkhorn, H. C.	Hughes, L. W.
Bien, F. A.	Kraemer, Manfred
Curtis, E. A.	
Dieffenbach, Richard H.	
Buvinger, C. W.	
Yaguda, Asher	

GLOUCESTER COUNTY

Downs, Elwood E.	None listed
Livengood, Baxter A.	
Pedrick, Wm. W.	

HUDSON COUNTY

Hasking, Arthur P.	Perkel, Louis L.
Klaus, Henry	Ginsberg, Geo.
Londrigan, Jos. F.	Sheeran, Vincent
Norton, James F.	Barishaw, Samuel B.
Pinkerton, Wm. A.	Comora, Herman C.
Kerdasha, G. S.	Daly, Edmund J.
McLoughlin, Frank J.	Simeone, Peter A.
Street, Daniel B.	Halligan, Earl J.
Brennock, Thos. McG.	Maver, Wm. W.
Justin, Arthur W.	Pearlstein, Frank
Butler, Vincent	Weiss, Abram
Callery, Wm. T.	Rieman, Aloysius P.
Little, Alonzo	Dougherty, Daniel D.
Williamson, Wm. L.	Shapiro, Maurice
Woodruff, Stanley R.	Doran, Ralph

HUDSON COUNTY—Continued

Delegates	Alternates
Conty, Anthony	Lawsing, Geo. C.
Spence, Henry	Pflug, F. J.
D'Acierno, Pellegrino	Mutter, Alfred A.
Chapman, Ellis	Waters, Edmund G.
Schuck, Traugott J.	Lupin, Edward E.
Pollak, Berthold S.	Madaras, John S.
Cosgrove, Samuel A.	O'Connor, J. J.
Evans, James L.	Fialk, Harry
Ballinger, Reeve L.	Schlein, August
Larkey, Chas. J.	Botti, John A.
Leining, Albert	
Quinn, John J.	

HUNTERDON COUNTY

Coleman, Austin H.	Gramsch, A. Louis
English, S. B.	Lane, Edgar W.
Fuhrmann, Barclay S.	Tompkins, Grenelle B.

MERCER COUNTY

Ackley, David B.	D'Arcy, W. E.
Bellis, Horace D.	Proctor, Francis E.
Seely, Roy B.	Warter, Peter J.
Swern, Nathan	Wilbur, Wm. L.
Connelly, John A.	Stone, Robert G.
Schildkraut, Jacob M.	Walsh, Thomas J.
Haggerty, D. Leo	Blackwell, Enoch
McGuire, Jas. A.	Blaugrund, Samuel
Hutchinson, A. Dunbar	Cottone, Rosario J.
North, Harry R.	Lavine, Barney D.
Vanneman, Jos. S.	McCullough, John H.
Fessler, Albert J.	Pessel, Johannes F.
Beairsto, E. B.	Wikoff, J. Leslie

MIDDLESEX COUNTY

Wilentz, Wm. C.	Wetterberg, Louis F.
Henry, Frank C.	Morris, Carlyle
McGovern, John F.	Kleiber, Estelle
Avery, Philip S.	Urbanski, Matthew F.
Weber, John P.	Sherman, Wm. E.
Haywood, Henry	Wantoch, Jos.
McKiernan, Robt. L.	McCormick, Wm. H.
Mann, Jacob J.	Gutowski, Jos. M.

MONMOUTH COUNTY

Blaisdell, C. Byron	Gordon, J. Berkley
Altschul, Frank J.	Kazmann, Harold A.
Magee, David M. P.	Wiener, Joseph
Pregnall, James P.	Villapiano, Jos.
Quirk, Martin	Manahan, Daniel V.
Rullman, Walter A.	Clayton, John C.
Maher, John E.	Edelson, Samuel

MORRIS COUNTY

Sherman, Byron G.	Teller, Daniel W.
Frost, Inglis F.	Spencer, Alvan
Teskey, Stanley	Harrington, J. Henry
McMahon, Bernard C.	

OCEAN COUNTY

Herbener, Eugene C.	Disbrow, Vanderhoef M.
Bunnell, Fred'k	

PASSAIC COUNTY

Delegates	Alternates
McBride, A. F.	Ryan, J. N.
Manly, T. E.	Hall, W. W.
Delario, A. J.	Johnsen, S. W.
Carlisle, J. H.	MacGuffie, R. N.
Morris, J.	Spickers, W.
MacMillan, W.	Okin, I.
Marsh, E. J.	Vosburgh, F.
Yates, J. S.	Shapiro, L. G.
Meloney, L. F.	Lomauro, J. R.
Willard, H. S.	Giambra, S. M.
Ginsberg, S.	
Harreys, C. W.	
Murn, C. J.	
Sullivan, W. M.	
Walker, H. G.	
Dwyer, W. A.	
Levinsohn, S. A.	

SALEM COUNTY

James, Wm. H.	Hummel, Ira L. C.
Dunn, John S.	Perry, Frank L.
Green, David W.	Fleming, Chas. L.

SOMERSET COUNTY

Renner, Dan S.	Cooper, Jos. H.
Hegeman, Runkle F.	Flint, Edgar T.
Long, Wm. H.	Brittain, Elmore G.

SUSSEX COUNTY

McCall, Jesse	None listed
Morrison, Fred A.	
Voorhees, Lamar	

UNION COUNTY

Lance, Elton W.	Drury, Alfred J.
Walsh, Ronald J.	Bishop, Carl
Burritt, Norman W.	Phelan, Walter
Brokaw, Christopher A.	Carlin, E. J.
Abel, Henri A.	Hallock, Wilton J.
Boyes, James C.	Runnells, John E.
Krans, Edward S.	Cantini, Raphael
Walsh, Thomas J.	Beisler, Lawrence G.
Murphy, Herschel	Blythe, Rowland
Armstrong, Lorrimer	Labow, Jos. J.
Lathrop, Frederic W.	Wegryn, Louis S.
Stein, Emil	Bloch, Harry
Harrison, Jos. B.	Leggett, Lindley
Weigel, Elmer P.	Davis, Stanton H.
Quinn, Stephen T.	Holland, Reuben
Hubbard, Harry V.	Casilli, Arturo R.
Schlichter, Chas. H.	Tidaback, John D.
Gelber, Isaac	Currie, Norman W.
Carpenter, Cedric C.	Peters, Richard
Morris, Watson B.	

WARREN COUNTY

Lyon, Chas.	Baldauf, Herman
Shimer, Floyd A.	Varney, Wm. H.
Curtis, Frank W.	Weres, James

NOMINATING COMMITTEE OF THE STATE MEDICAL SOCIETY, 1937

Chairman, Marcus W. Newcomb, Past President

County	Delegate	Alternate
ATLANTIC	Scanlan, D. Ward	None
BERGEN	Liva, Arcangelo	Alexander, Samuel
BURLINGTON	Haines, Edgar J.	Hornberger, J. H.
CAMDEN	Lee, Thomas B.	Wilson, L. R.
CAPE MAY	Way, Clarence W.	None
CUMBERLAND	Miller, H. G.	Myatt, L. E.
ESSEX	Stahl, Alfred	Mount, Walter B.
GLOUCESTER	Downs, Elwood E.	Pedrick, William
HUDSON	Londrigan, Jos. F.	McLoughlin, Frank J.
HUNTERDON	English, S. B.	Coleman, A. H.
MERCER	North, Harry R.	Haggerty, D. L.
MIDDLESEX	Mann, J. J.	Haywood, H.
MONMOUTH	Watkins, R. E.	Clayton, John C.
MORRIS	McMahon, Bernard C.	None
OCEAN	Herbener, Eugene	Bunnell, F.
PASSAIC	Bergin, Joseph	To be elected in April
SALEM	Green, D. W.	None
SOMERSET	Renner, D. S.	Hegeman, R. F.
SUSSEX	Coleman, J. G.	Johnson, George
UNION	Morris, Watson B.	Murphy, H. S.
WARREN	Curtis, Frank W.	Skinner, William F.

MEMBERSHIP OF COUNTY MEDICAL SOCIETIES

Comprising

THE MEDICAL SOCIETY OF NEW JERSEY

1 9 3 7

An asterisk (*) indicates a deceased member

ATLANTIC COUNTY (1)

Society organized June 7, 1880. Meets second Friday evening monthly, except in June, July, August and September. Annual Meeting in May.

President, Irvin, John S., Atlantic City

Vice-President, Read, Hilton S., Atlantic City

Secretary, Brown, J. Carlisle, Atlantic City

Treasurer, Allman, David B., Atlantic City

Reporter, Nickman, E. Harrison, Atlantic City

Historian, Harley, H. L., Atlantic City

Active Members

Allman, David B., 104 St. Charles pl., Atlantic City
Andrews, Clarence L., 1616 Pacific av., Atlantic City
Axilrod, Maurice Harry, 2620 Pacific av., Atl. City
Barbash, Samuel, 1902 Pacific av., Atlantic City
Bartlett, Clara K., 4301 Atlantic av., Atlantic City
Bassett, Norman H., Prof. Arts Bldg., Atlantic City
Beir, Ily R., 114 So. Virginia av., Atlantic City
Blampin, Winifred A., Galen Hall, Atlantic City
Bossert, Chas. L., 4021 Atlantic av., Atlantic City
Boysen, Theophilus H., 100 Phila. st., Egg H'rb'rC'y
Brown, J. Carlisle, 101 S. Indiana av., Atlantic City
Carrington, Wm. J., 905 Pacific av., Atlantic City
Chalfant, Wm. P., Jr., 7003 Ventnor av., Ventnor
Charlton, C. Coulter, 124 S. Illinois av., Atlantic City
Chew, Elisha C., 603 Pacific av., Atlantic City
Clark, S. Worth, 152 S. No. Carolina av., Atl. City
Cleary, Jos. P., Minotola
Conaway, Walt P., 1723 Pacific av., Atlantic City
Corson, Filbert R., 101 S. Indiana av., Atlantic City
Crane, Bernard, 306 Pacific av., Atlantic City
Dalton, Simon E., 117 S. Illinois av., Atlantic City
Darnall, Wm. E., 5 S. Morris av., Atlantic City
Davidson, Harold S., 101 S. Indiana av., Atl. City
Davis, Wm. C., 124 S. Illinois av., Atlantic City
deHellebranth, Roland T., 104 S. Fr'kf't av., Ventn'r
Diskan, Samuel M., 1904 Pacific av., Atlantic City
Donnelly, Wm. A., 60 N. Hartford av., Atlantic City
Durham, Royal E., 130 S. Illinois av., Atlantic City
Dyer, Ed. H., 102 S. Victoria av., Ventnor
Eckert, Walter L., 720 Shore rd., Somers Point
Elliott, Frazier J., 10 No. Second st., Hammonton
Ewens, Arthur E., 3600 Pacific av., Atlantic City
Feinstein, Louis, 410 Pacific av., Atlantic City
Fish, Clyde M., 15 W. Washington av., Pl's'ntville
Forsythe, Albert E., 44 N. Kentucky av., Atl. City
Fox, Wm. W., 101 S. Indiana av., Atlantic City
Frank, Myrtile, 227 Phila. st., Egg Harbor City
Gordon, Benj. L., 1616 Pacific av., Atlantic City
Gordon, Carl, 1712 Pacific av., Atlantic City
Grier, Robt. M., 50 E. Washington av., Pl's'ntville
Gruhler, Jean A., Prof. Arts Bldg., Atlantic City
Guion, Edw., Atl. Co. Hosp. for Ment'l Dis., N'rthf'd
Halpern, Samuel, 504 Pacific av., Atlantic City
Harley, Halvor L., 101 S. Indiana av., Atlantic City
Harvey, Edwin H., 20 N. Florida av., Atlantic City
Henderson, Kenneth P., 121 S. Illinois av., Atl. C'y
*Henry, Jonas A., Pleasantville
Hersohn, Wm. W., 116 S. Illinois av., Atlantic City
Hess, Louis E., 19 E. Bolton av., Absecon
Holoman, Mahlon B., 3 N. Granville av., MargateC'y
Holt, Edward Z., Children's Seashore Home, Atl.C'y
Hudson, Woodburn J., 123W.W'sh'gt'n av.,Pl's'ntv'le
Hyman, Charles, 2619 Pacific av., Atlantic City
Infield, G. L., 1401 Shore rd., Northfield
Irvin, John S., 1910 Pacific av., Atlantic City
Jacobson, John J., 1616 Pacific av., Atlantic City
Johnson, V. Earl, 101 S. Indiana av., Atlantic City
Kahn, Leo, 32 States av., Atlantic City
Kaighn, Chas. B., 905 Pacific av., Atlantic City
Kilduffe, Robt. A., 108 S. Nassau av., Margate City
Kline, Herman, 2627 Pacific av., Atlantic City
Krechmer, Abraham, 521 Pacific av., Atlantic City
Leonard, Isaac E., 2842 Atlantic av., Atlantic City
Lucas, Stanley L., 44 N. Kentucky av., Atlantic C'y
Mackler, Louis, 705 Pacific av. Atlantic City
Madden, Leland S., 21 E. Verona av., Pleasantville
Magill, Marcus, 4116 Ventnor av., Atlantic City
Major, Morton M., 4017 Ventnor av., Atlantic City
Marshall, Jos. C., 1517 Pacific av., Atlantic City
Marvel, Peter H., 2216 Shore rd., Northfield
Mason, James H., 1616 Pacific av., Atlantic City
*Massay, John P., Atlantic City
McGeehan, Stanley M., Ryanhurst Apt., Atlantic C'y
Merendino, Anthony G., 2720 Pacific av., AtlanticC'y
MeVay, James C. F., 2907 Pacific av., Atlantic City
Nickman, E. Harrison, 101 S. Newton av., Atl. City
Pennington, John, 101 E. Indiana av., Atlantic City
Pilkington, Albert, 117 S. Virginia av., Atlantic C'y
Poland, Geo. A., 206 E. Verona av., Pleasantville
*Poland, Joseph, Atlantic City
Quinn, Norman J., 3303 Pacific av., Atlantic City
Read, Hilton S., 5407 Atlantic av., Ventnor City
Reyner, Daniel C., 2703 Pacific av., Atlantic City
Rieck, Allan, 507 S. Shore rd., Pleasantville
Roop, Wm. O., 101 S. Indiana av., Atlantic City
Rosenberg, Louis, 26 S. Stenton pl., Atlantic City
Rosenblatt, Sidney, 1094 Pacific av., Atlantic City
Ruffu, Henry L., 111 S. Boston av., Atlantic City
Salasin, Samuel L., 511 Pacific av., Atlantic City
Scanlan, D. Ward, 15 S. Illinois av., Atlantic City
Schwarzkopf, Geo. C., 2901 Pacific av., Atlantic City
Scott, Karl McC., 1616 Pacific av., Atlantic City
Shenfeld, Isaac, 4806 Atlantic av., Atlantic City
Shimer, A. Burton, 606 Pacific av., Atlantic City
Shivers, Chas. H. deT., 121 S. Illinois av., Atl. City
Shore, Ernest L., 306 Atlantic av., Atlantic City
Silvers, Homer I., 16 S. Suffolk av., Ventnor
Sinkinson, Chas. D., Jr., 1616 Pacific av., Atl. City
Smith, Andrew M., 344 Phila. av., Egg Harbor City
Stalberg, Samuel, 3822 Ventnor av., Atlantic City
Stamps, Geo. R., 214 E. Verona av., Pleasantville
Stern, Samuel, 2815 Pacific av., Atlantic City
Stevenson, Alex. M., 7506 Ventnor av., Margate C'y
Stewart, Sloan G., Pacific & No.Carolina avs.,Atl.C'y

Stewart, Walter B., 8 N. Tallahassee av., Atl. City
Subin, Harry, 1616 Pacific av., Atlantic City
Surran, Carl A., 1616 Pacific av., Atlantic City
Timberlake, Baxter H., 1616 Pacific av., Atl. City
Uzzell, Edward F., 2703 Pacific av., Atlantic City
Walker, Levi M., 110 S. No. Carolina av., Atl. City
Weiner, Samuel E., 904 Pacific av., Atlantic City
Wescott, Wm. C., Pacific & Delaware avs., Atl. C'y
Westney, Alfred W., 3005 Pacific av., Atlantic City
Whims, Clarence B., 5401 Ventnor av., Ventnor
White, Rostin, Atl. Shores Hosp., Somers Point
Williams, Raym'd A., Swarthm're & Atl.avs.,V'ntn'r
Wilson, Lawrence A., 114 N. Shore rd., Absecon
Winn, Samuel L., 1616 Pacific av., Atlantic City

Honorary Members

James, Henry C., Mays Landing
Marcus, Jos H., 1185 Park av., New York City

Number of active members and basis of representation, 115, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937.

BERGEN COUNTY (2)

Society organized February 28, 1854. Meets on second Tuesday of each month, except July and August. Annual Meeting in May.

President, Irwin, J. H., Englewood

Vice-President, Littwin, Charles, Palisade

Secretary, Knowles, Geo. M., Hackensack

Treasurer, Markley, L. A., Teaneck

Reporter, Black, LeRoy W., Rutherford

Active Members

Abbate, Chas. C., 32 Main st., Lodi
Alexander, Samuel, Main st., Park Ridge
Anderson, Reuben M., 408 Main st., Hackensack
Angelillis, Paul, 76 State st., Hackensack
Appold, Geo. D., 60 E. Church st., Bergenfield
Baketel, H. Sheridan, 155 Van Wagenen av., Jer.C'y
Baldwin, John Francis, 1474Windsor rd.,W.Englew'd
Barlow, Geo. B., 63 Spring lane, Englewood
Barnes, Wm. J., 155 Engle st., Englewood
Barroso-Bernier, Adalberto, 173 Morse pl., Englew'd
Basralian, Jos. B., 238 Boulevard, Hasbr'k Heights
Berke, Raynold N., 430 Union st., Hackensack
Bernardini, Oddino, 266 John st., Oradell
Beyer, Wm., 612 Undercliff av., Edgewater
Black, LeRoy W., 3 Addison av., Rutherford
Blauvelt, Grace B., 123 Prospect st., Ridgewood
Bleasby, Chas. B., 136 Passaic st., Garfield
Blenkle, Victor A., 140 Chadwick rd., Teaneck
Bono, Jos. J., Paris av., Northvale
Branon, M. E., 76 Ames av., Rutherford
Brennan, Alfred T. V., Jr., 275 Engle st., Englew'd
Brennan, Ralph J., 300 Howard av., Fair Lawn
Brown, John L., 647 Anderson av., Grantwood
Burnham, Lyman, 229 Engle st. Englewood
Burns, Geoffrey C. H., County rd. & So. st.,Demarest
Busicco, Philip S., 131 Liberty rd., Englewood
Byers, Clarence W., 176 Union av., Rutherford
Calabrese, D. J., 139 Rochelle av., Rochelle Park
Caldroney, Thos. L., 66 Bergen av., Ridgefield Park
Campbell, James M., 105 S. Central av., Ramsey
Candio, Vincent P., 347 Ridge rd., Lyndhurst
Carroll, Thomas R., 755 Anderson av., Grantwood
Cartnick, Louis C., 196 Hackensack st., Wood Ridge
Chase, Kalman, 591 N. Maple av., Hohokus
Clarie, D'Arcy C., 526 Broad av., Ridgefield
Clarke, Edward W., 435 Warwick av., W. Englew'd
Clock, Ralph O., 433 W. 51st st., New York City
Cloud, Albert W., 109 E. Palisade av., Englewood
Cochrane, Cleland D., Main st., Closter
Connor, Clarence A., 1586 Center av., Fort Lee
Conover, Ellsworth E., 267 Madison av., Hasbr'kHts.
*Conrad, E. K., Hackensack
Cooper, Howard M., 37 Ridge rd., Rutherford
Coppoletta, Jos. M., Jr., 452 Palisade av., CliffsideP'k
Corn, David, 119 Park st., Ridgefield Park
Costabile, Vincenzo, 150 Ridge rd., Lyndhurst
Crandall, John K., 200 Main st., Fort Lee
Cropsey, Chas. D., 168 Chestnut st., Rutherford
Curtis, Donald A., 241 Union st., Hackensack
D'Agostin, Henry, 243 Fulton ter., Cliffside
Dayton, Spencer T., 86 Demarest av., Englewood
DeBiaso, Cornelius V., 9 W. Park pl., Rutherford
DeSanto, Anthony M., 337 Essex st., Hackensack
Dezer, Chas. N., Jr., 210 Main st., Hackensack
Dickson, John D., 202 Larch av., Bogota
Dilger, Fredk. G., 210 Main st., Hackensack
Douglass, Richmond, 155 Engle st., Englewood
Edwards, J. Bennett, 144 Woodridge pl., Leonia
Ellmers, Basil J., 230 New Milford av., New Milford
Essertier, Edward P., 273 State st., Hackensack
Farmer, Vincent, 288 State st., Hackensack
Farr, Walter J., 288 Griggs av., Teaneck
Fermaglich, H. B., 881 Garrison av., Teaneck
Ferrari, Andrew F., 110 Hackensack av.,E.Rutherf'd
Finke, Geo. W., 237 State st., Hackensack
Finke, John H. D., 19 Hudson st., Hackensack
FitzHugh, Wm. F., 65 Bergen av., Ridgefield Park
FitzPatrick, Leo J., 134 Bergen av., Ridgefield Park
Forte, Fulvio Chester, 65 Hudson st., Hackensack
Franklin, Sidney I., 15 Tenafly rd., Englewood
Freeland, Frank, 281 State st., Hackensack
Friedman, Abraham I., 145 Marshall av., LittleFerry
Garrett, Harry S., Park av., Park Ridge
Gershman, Jos. G., 99 W. Madison av., Dumont
Gilady, Raphael, 205 Union st., Hackensack
Gittelsohn, Isador, 896 Kinderkamack rd.,RiverEdge
*Gnassc E. R., Fort Lee
Goldberg, David, 7 Bogert pl. ,Westwood
Goldfarb, Abraham, 52 Chestnut st., Rutherford
Greenfield, Arthur W., 50 Anderson st., Hackensack
Greenfield, Wm. J., 50 Anderson st., Hackensack
Grimes, Jesse R., 214 Washington av., Dumont
Groff, Parker A., 159 Washington av., Little Ferry
Grossman, Rubin, 81 Somerset st., Garfield
Hallett, Fredk. S., 200 Passaic st., Hackensack
Halpern, Herman, 143 Engle st., Englewood
Harryman, Wm. K., 271 Union st., Hackensack
Helff, Jos. R., 1367 Teaneck rd., W. Englewood
Heller, Geo., 100 E. Palisade av., Englewood
Hitzemann, Louis A., 30 E. Passaic st., Maywood
Hoheb, Albert S., 5 Lincoln av., Rutherford
Horowitz, Herman J., 872 Broad av., Ridgefield
Huff, Edmund N., 97 Engle st., Englewood
Hull, Donald B., 7 W. Ridgewood av., Ridgewood
Iannuzzi, Ernesto, 597 Palisade av., Cliffside Park
Irwin, John H., 51 Tenafly rd., Englewood
Johnson, G. Leonard, Jr., 390 Booth av., Englewood
Johnston, Rufus O., Railroad av., Harrington Park
Johnston, Sidney F., 365 Rochelle av., Rochelle P'k
Jukofsky, Isidore D., 32 Union pl., Ridgefield Park
Kakascik, Emil, 206 Palisade av., Garfield

Kanning, Fredk. R., W. Allendale av., Allendale
Kastler, Franz, 54 Ames av., Rutherford
Keir, Floyd E., 308 Engle st., Englewood
Kennedy, Paul A., 58 Tenafly rd., Englewood
King, Chester A., 410 Kinderkamack rd., Oradell
Kingslow, Geo. L., 346 First st., Hackensack
Knapp, Richard E., 25 Hudson st., Hackensack
Knight, Wm. T., Jr., 515 Oradell av., Oradell
Knowles, Geo. M., 241 Main st., Hackensack
Knox, Chas. A., 138 Bergen av., Ridgefield Park
Knox, Harriet L., 390 Union st., Hackensack
Kraissl, Cornelius J., 393 Main st., Hackensack
Kroll, Mark M., Union av., Cresskill
*Lansing, T. B., Pine Rest, Tenafly
Legato, Samuel F., 417 Palisade av., Cliffside Park
Lesko, Stephen W., 663 Main av., Passaic
Levitas, Geo. M., 77 Fairview av., Westwood
Levitas, Irving M., 77 Fairview av., Westwood
Lewis, Alice B., E. Saddle River rd., Saddle River
Littwin, Chas., 962 Queen Anne rd., Teaneck
Liva, Arcangelo, 5 Pangborn pl., Hackensack
Liva, G. Albin, Madison & Franklin avs., Wyckoff
Lueddecke, Roland E., 216 Randolph av., E.Ruth'rf'd
Lynch, Maurice M., 396 Union st., Hackensack
Lyons, Romola L. K., 171 Meadowbr'k rd., Englew'd
Macaulay, Francis Archibald, 815 Elm av., Teaneck
MacKellar, James M., 26 E. Clinton av., Tenafly
Mader, Anthony I., Jr., 430 Union st., Hackensack
Magee, Henry R., 408 Main st., Hackensack
Mancene, Edward M., 328 Stuyvesant av., Lyndhurst
Markley, Luther A., Holy Name Hospital, Teaneck
McCormack, Frank C., 95 Tenafly rd., Englewood
McFeely, Percy R., 242 Palisade av., Bogota
McGuire, Jos. T., 77 Autumn st., Lodi
McLane, A. Donald, 498 Engle st., Englewood
Mears, Wm. G., 22 Overlook av., Leonia
Meyer, Howard M., 400 Maple Hill dr., Hackensack
Miller, Theo. R., 316 State st., Hackensack
Mockett, Walter W., 714 Palisade av., Cliffside Park
Moran, Helen C., 151 Engle st., Englewood
Morrow, Jos. R., Bergen Pines Hosp., Oradell
Muller, Fredk. L., 413 Third st., Carlstadt
Mulligan, Luke A., 230 Central av., Leonia
Myers, Norman V., 301 Knickerbocker rd., Tenafly
Netz, Lester W., 414 Main st., Hackensack
Neville, Robert J., 547 Main st., Hackensack
Nicol, Lorenz C., 360 Larch av., Bogota
O'Brien, Paul, 196 Main St., E. Rutherford
Oren, Hyman, Park av., Park Ridge
Pagano, Peter, 45 N. Broad st., Ridgewood
Pallen, Conde deS., 6 Passaic st., Rochelle Park
Patti, Frank A., 340 Broad st., Leonia
*Payawall, J. L., Ramsey
Payne, Jos., 223 Godwin av., Midland Park
Pedevill, Jos. R., 232 Highland av., Palisade Park
Perham, Roy G., 248 Boulevard, Hasbrouck Hgts.
Pettit, Harry H., 138 Franklin av., Ridgewood
Phillips, Walter, 109 E. Palisade av., Englewood
Pindar, Arthur W., 627 Queen Anne rd., Teaneck
Pindar, Irene C. D., 627 Queen Anne rd., Teaneck
Pingitore, Eufelia, 412 Main st., Hackensack
Pitkin, Geo. P., 4 S. Washington av., Bergenfield
Prather, Chas. G., 260 Westwood av., Westwood
Prather, John W., 155 Washington av., Dumont
Probst, Everett W., 19 Hasbrouck pl., Rutherford
Proctor, J. W., 100 Eagle st., Tenafly
Prout, Wm. B., 88 W. Forrest av., W. Englewood
Pullen, Guy F., 111 Leonia av., Leonia
Rader-Hoheb, Katherine A., 5 Lincoln av., Ruth'rf'd
Reich, Samuel B., 348 Kinderkamack rd., Oradell
Reid, Erwin W., 125 Marsellus pl., Garfield
Reinhold, Herbert E.,441W.Englew'd av.,W.Englew'd
Richardson, Chas. A., Main st., Closter
Richie, Emory W., 172 James st., Hackensack
Robinson, Silas E., Franklin Turnpike, Waldwick
Romano, Anthony M., 134 Broadway, Hillsdale
Rowe, Jos. A., 247 Franklin av., Ridgewood
Rube, Jos. A., 145 Prospect st., Ridgewood
Rucker, Wm. C., 408 Main st., Hackensack
Ryley, Harold W., 1 Lincoln pl., E. Rutherford
Schmidt, Walter W., 386 Palisade av., Cliffside P'k
Scullion, Arthur A., 460 Anderson av., Cliffside
Sealey, Henry J., 79 Washington av., Dumont
Segard, Christian P., 204 Glenwood av., Leonia
Sexton, Edward V., 176 Edgemont ter., Teaneck
Seymour, Edward T., 55 Hillside av., Tenafly
Skvarla, John A., 17 Koster st., Wallington
Smaine, Enrique delC., 549 Monroe st., Carlstadt
Snedecor, Spencer T., 50 Anderson st., Hackensack
Spiegelglass, Abraham B., 417 Main st., Hack'ns'k
*Swayze, A. A., 280 State st., Hackensack
Taylor Harold W., 247 Mountain rd., Englewood
Teeter, John N., Lydecker st., Englewood
Tennis, Edgar M., 240 Engle st., Englewood
Tether, Russell K., Main st., Closter
Toal, Jos., 803 Prospect av., Ridgefield
Trossbach, Herman, 97 Palisade av., Bogota
Tyson, Frances B., 101 Leonia av., Leonia
Vanderbeek, S. W., 143 Engle st., Englewood
VanDyke, Jos. S., 42 W. Palisade Blvd., PalisadesP'k
Van Winkle, Chas. I., 14 E. Park pl., Rutherford
Villegas, Juan A., 302 Day st., Fairview
Vroom, Wm. L., 7 W. Ridgewood av., Ridgewood
Walsh, Thos. M., 210 Kipp av., Hasbrouck Heights
Ward, Alfred W., Main st., Closter
Ward, Geo. H., 240 Engle st., Englewood
Warren, Chas. B., 181 S. Prospect av., Bergenfield
Webb, Wilson D., 316 State st., Hackensack
Werner, E. A., 2 S. Dwight pl., Englewood
White, Frank S., 190 Carlton ter., Teaneck
Whitman, Lloyd B., 7 W. Clinton av., Bergenfield
Whittaker, Neil McL., 418 Main st., Hackensack
Widetsky, Alfred, 85 Broadway, E. Paterson
Williams, Wm. C., 9 Ridge rd., Rutherford
Willis, Benedict P., 23 Park av., Rutherford
Wilson, Harrison B., 430 Union st., Hackensack
Winter, Gladys C., 717 Norma ct., Teaneck
Witkoff, Ben, 190 Hackensack st., Wood Ridge
Wolfe, Edward E., 1304 Teaneck rd., W. Englewood
Wolowitz, Harry B., 20 Spring Valley rd., Hack'ns'k
Worcester, Geo. F., 220 Engle st., Englewood
Wry, Orlin V., 95 High st., E. Rutherford
York, James L., 331 River rd., New Milford
Zacchino, Arnold, 1156 Palisade av., Palisade

Associate Members

Coca, Arthur F., 425 Grant av., Oradell
Colonna, P. C., Englewood
Denison, Ward C., 123 Prospect st., Ridgewood
Harreys, Chas. W., 715 Broadway, Paterson
Hickey, C. M., 464 Churchill rd., W. Englewood
Inge, G. A. L., 150 Winthrop rd., Englewood
James, W. L., 328 Undercliff av., Edgewater
Leonard, F. S., Jr., 9 Wash. av., Tenafly
Liddy, Frank J., Franklin Turnpike, Mahwah
Lowry, Thomas, 112 Prospect st., Ridgewood
Opitz, Russell B., 218 Brindle way, Palisade
Policastro, N. C., 378 Union st., Hackensack
Randazzo, A. P., 82 Prospect st., Passaic
Sandler, Samuel A., 5 Pangborn pl., Hackensack
Spickers, Wm., 6 Church st., Paterson
Stone, Chas. T., 106 N. Monroe st., Ridgewood
Twinem, Francis P., 228 Anderson st., Hackensack

Honorary Members

Clock, Ralph O., 433 East 51st st., New York City
Proctor, James W., 188 Engle st., Tenafly
Riordon, J., 110 Maple st., Rutherford

Transferred

Benjamin, J. F., to Passaic Medical Society
White, Richard E., to Passaic Medical Society
Yachnin, Samuel C., to Passaic Medical Society
Tudor, Chas., to Nassau County Medical Society
Reid, T. F., to Dover, N. H., County Medical Society
Wurts, Margaret M., to Essex County Medical So.

Number of active members and basis of representation, 222, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937.

BURLINGTON COUNTY (3)

Society organized May 19, 1829. Meets second Thursday of each month, except June, July and August. Annual Meeting in November.

President, Small, E. Lester, Medford

Vice-President, Fahrenbruch, Fredk. D., Mt. Holly

Secretary, Rodman, E. Warren, Beverly

Treasurer, Davis, E. Vernon, Vincentown

Reporter, Scott, Parry M., Beverly

Active Members

Anderson, Richard D., 465 High st., Burlington
Bauer, Harry W., 515 Maple av., Palmyra
Bray, Wm. E., 41 Elizabeth st., Pemberton
Busansky, Samuel T., Circle dr., Browns Mills
Clement, John B., 209 Warren st., Beverly
Conroy, John S., 122 E. Broad st., Burlington
Curtis, Howard C., 129 Chester av., Moorestown
Darlington, Emlen P., New Lisbon
Davis, Elbert V., Vincentown
Davis, Jacob M., 1400 High st., Burlington
Downs, Roscius I., 40 Scott st., Riverside
Fahrenbruch, Fredk. D., 101 Garden st., Mt. Holly
Geary, Russell D., Riverside
Gladen, Ralph G., New Lisbon
Haines, Edgar J., Medford
Haldeman, Robt. E., Mt. Holly
Hartman, Luther M., 82 E. Main st., Maple Shade
Hollingshead, Lyman B., Pemberton
Hornberger, Jennings H., Roebling
Hunter, Edward R., Delanco
Imhoff, Robt. E., 29 E. Main st., Moorestown
Kuder, Jos. M., 104 Garden st., Mt. Holly
LeFavor, Dean H., 619 Morgan av., Palmyra
Longsdorf, Harold E., Mt. Holly
Love, Elizabeth F., 142 E. Oak av., Moorestown
Lucas, Wm. F., 23 W. Broad st., Burlington
McDonnel, Gerald E., 41 Cherry st., Mt. Holly
Mark, Harry B., Broad & Elm sts., Riverton
Mendenhall, Clinton D., 412 Farnsworth av.,B'rd'nt'n
Metzer, Emma P. W., 430 Fairview st., Riverside
Meyer, Eugene A., Moorestown
Mills, Chas. S., 106 Lippincott av., Riverton
Muldoon, Edw. J., Florence
Mulford, Ephraim R., 100 E. Broad st., Burlington
Munro, Chas. A., Marlton
Newcomb, Marcus W., Browns Mills
Peacock, Arthur B., Columbus
Remer, Daniel F., 417 High st., Mt. Holly
Rodman, E. Warren, 503 Cooper st., Beverly
Rogers, Harry L., 408 Main st., Riverton
Schisler, Milton M., 2nd & Church sts., Florence
Scott, Parry M., 466 Cooper st., Beverly
Shapiro, Chas. S., Maple Shade
Shipps, Hammell P., 739 Chestnut st., Delanco
Small, Edward L., 30 Branch st., Medford
Stokes, Jos., 220 E. Main st., Moorestown
Stokes, S. Emlen, 129 Chester av., Moorestown
Summey, Thos. J., Moorestown
Thorne, Nathan, Moorestown
Tracy, Geo. T., Beverly
Ulmer, David H. B., 199 Chestnut st., Moorestown
Viteri, Luis E., 13 Brainerd st., Mt. Holly
Wagner, J. Geo., Delanco
Wells, Wm. C. V., Delanco
Wyman, Edward H., 100 E. Broad st., Burlington

Honorary Members

Wilkinson, Geo. H., Moorestown

Number of active members and basis of representation, 55, Feb. 5, 1937.

CAMDEN COUNTY (4)

Society organized August 14, 1846. Meets first Tuesday in each month, October to May inclusive, with an outing in June. Annual Meeting in May.

President, Buzby, B. Franklin, Camden

Vice-President, Mahaffey, J. Lynn, Camden

S cretary, Gamon, Robt. S., Camden

Treasurer, Shull, E. C., Camden

Reporter, Barnshaw, Harold D., Camden

Historian, Schrack, Helen F., Camden

Censors, Lewis, T. K., Camden
Davis, A. B., Camden
Hummel, E. G., Camden
Lee, Thos. B., Camden
Shafer, F. Wm., Camden

Active Members

Adams, Geo. B. McC., 304 Monmouth st., Gloucester
Anderson, Wm. M., 20 King's Hghwy. W., Hadd'nf'd
Andrus, David L., 805 Cooper st., Camden
Assante, Mario H., Evesham av., Magnolia
Athey, Kenneth L., 3616 Westfield av., Camden
Bailey, Wilson G., 512 Broadway, Camden
Baker, Banks S., 601 Walnut st., Camden
Baker, Maurice E., 1149 Kaighn av., Camden
Barb, Kirk B., 1303 Princess av., Camden
Barnshaw, Harold D., 2626 Federal st., Camden
Barroway, James N., 3064 Federal st., Camden
Becker, Chas F., 620 Benson st., Camden
Beideman, Casper M., 5 W. Maple av., Merch'ntv'le
Bentley, David F., Jr., 406 Cooper st., Camden
Betancourt, Raul R., 406 Cooper st., Camden
Braun, Wm., 4307 Maple av., Merchantville
Brennan, Chas. L. S., 14 S. Broadway, Glouc'st'r C'y
Brennan, John P., 429 Cooper st., Camden
Brown, Stanley L., Glen av., Laurel Springs
Browning, W. Kempton, 120 N. Center st.,M'rch'tv'le
Browning, Wm. J., II, 134 N. Center st., M'rch'tv'le
Burns, Wilmer F., 267 White Horse Pike, Audubon

Bush, Ralph K., 131 E. Park av., Merchantville
Buzby, B. Franklin, 414 Cooper st., Camden
Carlander, Oswald R., 1972 Browning rd.,M"rch'tv'le
Casselman, Arthur J., 301 N. Second st., Camden
Ciliberti, Frank J., Jr., 5th & Pine sts., Camden
Clark, Ernest W., 209 Haddon av., Westmont
Clement, Lavinia B., 124 Kings Hwy. W., Hadd'nf'd
Collier, Martin H., Lakeland Sanatorium, Grenloch
*Conoly, Lacy N., 601 Walnut st., Camden
Corpening, Flave H., Park av., Laurel Springs
Coxson, Harold P., Laurel rd., Stratford
Crist, Walter A., 725 Collings av., W. Collingswood
Crowley, Jos. W., 4005 Westfield av., Camden
Davis, Albert B., 511 Cooper st., Camden
Day, Grafton E., Frazer & N. J. avs., Collingswood
Decker, Henry B., 527 Penn st., Camden
Deibert, Irvin E., 618 Benson st., Camden
Del Duca, Vincent P., 406 Cooper st., Camden
Denbo, Elic A., 854 Haddon av., Camden
DiIelsi, Anthony J., 1013 S. 5th st., Camden
Driscoll, Chas. D., 6 White Horse Pk., Hadd'n Hgts.
Eaton, Arthur T., 201 Fourth av., Haddon Heights
Ellis, Alexander, 513 Broadway, Camden
Elwell, Alfred M., 407 Cooper st., Camden
Evans, Winborne D., 2704 Westfield av., Camden
Ewing, Leslie H., 10 Broad st., Berlin
Eynon, Harold K., 579 Haddon av., Collingswood
Farrell, Edgar A. H., 100 Kings Hwy. W., Hadd'nf'd
Fessman, John W., Jr., Clements Br. rd.,Runnemede
Filkins, Cedric E., 418 White Horse Pk., Audubon
Fisher, Stella C., 4405 Westfield av., Camden
Gamon, Robt. S., 527 Cooper st., Camden
German, Geo. B., 429 Cooper st., Camden
Glover, L. L., 53 Kings Highway, W., Haddonfield
Goldman, Samuel, 7th and State sts., Camden
Goldstein, Hyman I., 1425 Broadway, Camden
Grenhart, Geo. W., 430 Haddon av., Camden
Hadley, Chas. F., 210 W. Maple av., Merchantville
Haines, Mabel C. S., 600 White Horse Pike, Audubon
Haines, Wm. H., 600 White Horse Pike, Audubon
Hallinger, Earl S., 517 Cooper st., Camden
Hammett, Lee J., 760 North 27th st., Camden
Hanson, Alfred S., 533 Monmouth st., Gloucester
Harris, Edwin A., 7 Oxford av., Stratford
Hays, Roy G., 567 Haddon av., Collingswood
Hemphill, E. H., 232 Kings Highway E., Haddonf'ld
Hessert, Edmund C., 700 Haddon av., Collingswood
Hirst, Ernest R., 634 Federal st., Camden
*Hirst, Levi B., 634 Federal st., Camden
Hollinshed, Beulah S., 600 Benson st., Camden
Horner-Rodger, Clara L., 721 Cooper st., Camden
Howard, John E., 67 Kings Highway W., Haddonf'ld
Hughes, Thos. E., 223 Cooper st., Camden
Hummel, Ernest G., 414 Cooper st., Camden
Hummel, Merwin L., 135 N. Center st., Merchantville
Hutcheson, Chas. R., 517 Cooper st., Camden
Jack, H. Wesley, 920 W. Haddon av., Collingswood
Jackson, Chas. H., 1250 Park blvd., Camden
Jarrett, Harry, 923 Broadway, Camden
Johnson, Chas. H., 632 Benson st., Camden
Jones, John C., 805 Princeton av., Camden
Kain, Thos. M., 403 Cooper st., Camden
*Kain, Wm. W., Cape May Court House
Keyser, David, West Jersey Homeo. Hosp., Camden
Kinney, Albert G., 917 Haddon av., Collingswood
Kline, Oram R., 414 Cooper st., Camden
Kutner, Chas., 1005 S. 5th st., Camden
Larossa, Ernest A., 708 Cooper st., Camden
*Leavitt, John F., 522 N. 3rd st., Camden
Lee, Thos. B., 622 Cooper st., Camden
Lewandowski, S. S., 1450 Mt. Ephraim av., Camden
Lewis, Thos. K., 47 So. 27th st., Camden
*Lippincott, A. Haines, 406 Cooper st., Camden
Lovett, Jos. C., Municipal Hos. for Con. Dis., C'md'n
Lyon, Leslie C., P. O. Box 63, Magnolia
Macalister, Alex., 626 Federal st., Camden
MacAlpine, K. B., 308 Monmouth st., Gl'cst'r City
McCallum, A. S., 213 Clements B'dge rd., Bar'ngt'n
McCarthy, Arthur M., 2772 Federal st., Camden
McConaghy, Thos. P., 10th & Cooper sts., Camden
McDermott, Vincent T., 511 State st., Camden
McGlade, Thos., H., 2953 Yorkship Square, Camden
Madden, Theophilus W., 16 Frazer av., Collingsw'd
Magee, Edward S., 604 White Horse Pike, Oaklyn
Magee, Russell S., 201 White Horse Pike, Audubon
Mahaffey, Jesse L., 414 Cooper st., Camden
Maldeis, Albertos, 117 N. 6th st., Camden
Marcarian, Henry G., 904 Cooper st., Camden
Marcy, John W., 117 E. Park av., Merchantville
Mecray, Paul M., 405 Cooper st., Camden
Mengel, Willard G., 400 Penn st., Camden
Meyer, Geo. P., 410 Haddon av., Camden
Miller-Richardson, Emma, 577 Stevens st., Camden
Moore, Frank Fawcett, 201 Evergreen av., W'dlynne
Murray, Edwin N., 558 Newton av., Camden
Ornaf, Ignace E., 1145 Thurman st., Camden
Osmun, Milton M., 611 Broadway, Camden
Palm, Howard F., 614 N. 2nd st., Camden
Phillips, Claude B., 891 Haddon av., Collingswood
Pike, Chas. E., 411 Newton av., Oaklyn
Pinsky, M. Myer, 944 S. 5th st., Camden
Pratt, Arthur G., 516 Cooper st., Camden
Pratt, Wm. H., 516 Cooper st., Camden
Principato, Roberto, 402 Walnut st., Camden
Raughley, Wm. C., Taunton av., Berlin
Read, Wm. T., Jr., 429 Cooper st., Camden
Reilly, James J., 622 Penn st., Camden
Rhone, David S., 1202 Haddon av., Camden
Ristine, Edwin R., Westville
Roberts, Jos. E., Jr., 403 Cooper st., Camden
Rogers, Edward B., 814 Haddon av., Collingswood
Ross, Alexander S., 542 Cooper st., Camden
Rossell, Edward W., 801 Cooper st., Camden
*Roth, Robert, Westmont
Ruttenberg, Max, 303 Cooper st., Camden
Saunders, Orris W., 1700 Broadway, Camden
Schall, Reuben E., 537 N. 7th st., Camden
Scheffler, Wilhelm A. H., 511 Cooper st., Camden
Schellenger, Ed. A. Y., 429 Cooper st., Camden
Schrack, Helen F., 216 N. 5th st., Camden
Schwartz, Henry C., Raritan av., Atco
Schruggs, Wm. J., 3005 Kearsage av., Camden
Shafer, Albert H., 405 Cooper st., Camden
Shafer, Fredk. W., 634 Penn st., Camden
Sharp, Jennie S., 719 Cooper st., Camden
Sharp, Reuben L., 719 Cooper st., Camden
Shaw, Ernest B., 811 Collings av., W. Collingswood
Sheaffer, Clinton P., 241 Kings Highwy. E., H'd'nf'ld
Shemeley, Wm. G., 7 Haddon av., Camden
Sheppard, Robt. L., 768 No. 27th st., Camden
Sherk, A. Lincoln, 2647 Westfield av., Camden
Shipman, James S., 542 Cooper st., Camden
Shope, Edward P. L., 511 Cooper st., Camden
Shull, Elliott C., 517 Cooper st., Camden
Sieber, Isaac G., 204 Merchant st., Audubon
Smith, James D., 701 N. 6th st., Camden
Smith, Wilbur A., 2 E. Clinton av., Oaklyn
Stein, Jos. M., 956 Newton av., Camden
Stephenson, Daniel H., 213 Haddon av., Ha'd'nf'ld
Stimus, Howard G., 300 Kaighn av., Camden
Stone, Arthur L., 2838 Berkley st., Camden
Summerill, Garnett, 330 Cooper st., Camden
Swiecicki, M. E., 317 Clements B'dge rd., Barringt'n
Tatem, Henry R., Jr., Pine st. & Atl. av., Audubon
Thompson, Penrose H., 4612 Westfield av., Camden
Van Sciver, John E. L., 106 Broadway, Camden
Ward, Lettie A., 325 Cooper st., Camden
Warwick, Ralph A., 3300 Federal st., Camden
Watkins, Geo. R., Warwick rd., Magnolia
Weimann, Max L., 803 Station av., Haddon Heights

West, Gordon F., 527 Penn st., Camden
Wheatland, Marcus F., 727 Walnut st., Camden
Wiant, Herman E., 120 Windsor av., Haddonfield
Wilson, Isam E., 110 Chapel av., Merchantville
Wright, Ralph S., 428 Richey av., Collingswood
Wroblewski, Benj. M., 1166 Thurman st., Camden

Honorary Members

Day, Grafton E., Collingswood
Ward, Lettie A., 325 Cooper st., Camden

Transferred

Baker, Banks S., from Somerset Co. Medical Society
Ristine, E. R., from Gloucester Co. Medical Society
Favorite, Grant O., to Phila. Medical Society

Number of active members and basis of representation, 174, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937.

CAPE MAY COUNTY (5)

Society organized December 18, 1883. Four regular meetings each year. Semi-annual meeting in April. Annual Meeting in October. Other two meetings at call of the President.

President, Townsend, John B., Ocean City

Vice-President, Tomlin, H. Hurlburt, Wildwood

Secretary, Robbins, Warren D., Cape May

Treasurer, Tomlin, H. Hulburt, Wildwood

Censors, Corson, Allen, Ocean City
Hughes, Frank R., Cape May
Ziegler, Oscar F., Wildwood

Active Members

Bernheisel, Louis E., Reading av., Tuckahoe
Corson, Allen, 824 Wesley av., Ocean City
Crowe, Aldrich C., 735 Atlantic av., Ocean City
Cryder, Millard C., Cape May Court House
Dandois, Geo. F., Wildwood
Darby, Chas. E., Plymouth & Atlantic avs., OceanC'y
Friedland, Arnold J., Woodbine
Friedland, Ida Monosson, Woodbine
*Gandy, Charles M., Ocean View
Gidding, Samuel S., 154 E. Spicer av., Wildwood
Haines, Willits P., Ocean City
Hornstine, Harry H., Wildwood
Hughes, Frank R., C'l'mbia av. & Oc'n st., Cape May
Jonas, August, 218 E. Pine av., Wildwood
Mace, Margaret, 2410 Atlantic av., N. Wildwood
Pettit, Herschel, 807 Wesley av., Ocean City
Robbins, Warren D., 202 Ocean av., Cape May
Steel, Wm. A., Beesley Point
Tomlin, Henry Hurlburt, Magnolia & Atl.avs.,W'dw'd
Townsend, John B., 824 Wesley av., Ocean City
Way, Clarence W., Sea Isle City
*Way, Eugene, Sea Isle City
Way, Julius, Cape May Court House
Whiticar, John H., Ocean City
Ziegler, Oscar F., 201 E. Pine av., Wildwood

Transferred

Hallinger, Earl S., Jr., to Gloucester Co. Medical Soc.

Number of active members and basis of representation, 23, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937.

CUMBERLAND COUNTY (6)

Society organized June 16, 1816. Meets on the second Tuesday of October, December, February, April and June. Annual Meeting in April.

President, Walker, H. Burton, Vineland

Vice-President, Myatt, L. E., Bridgeton

Secretary, Branin, H. S., Millville

Treasurer, Wilson, H. H., Bridgeton

Active Members

Bacon, Mary, 278 Commerce st., Bridgeton
Baker, Hugh W., Vineland
Bellak, Ellis R., Leesburg
Bennett, Samuel D., 118 Pine st., Millville
Berkowitz, Benj., 20 Bank st., Bridgeton
Bostwick, Delazon S., Cumberland Hotel, Bridgeton
Branin, Howard S., 200 W. Main st., Millville
Butcher, Chas., Heislerville
Clippinger, Richard D., 220 S. West av., Vineland
Cornwell, Alfred, 265 N. Laurel st., Bridgeton
Corson, Elton S., 135 E. Commerce st., Bridgeton
Corson, Kenneth E., 25 So. Myrtle st., Vineland
Cunningham, Chas., Jr., 7th & Wood sts., Vineland
Davies, George A., 53 Front st., Elmer
Day, Samuel T., Port Norris
Garrison, Walter S., Cedarville
Giacalone, Vincenzo, 649 Landis av., Vineland
Gray, Chas. M., 6th & Grape sts., Vineland
Harris, Allan, Greenwich
Kauffmann, Louis J., 232 N. 2nd st., Millville
Knowles, James S., 318 N. 2nd st., Millville
Lloyd, Reba, 31 W. Commerce st., Bridgeton
Loder, Horace B., 225 E. Commerce st., Bridgeton
Loper, John C., 129 Atlantic st., Bridgeton
Lore, Harry E., Cedarville
Lyon, Earl C., 194 E. Commerce st., Bridgeton
Mayhew, Chas. H., 329 Pine st., Millville
Mezzetti, Alfred F., 220 S. 6th st., Vineland
Miller, Harry G., 205 E. Main st., Millville
Myatt, Leslie E., 98 N. Pearl st., Bridgeton
Neal, Chas. B., Pine & 3rd sts., Millville
Oliver, David H., 188 E. Commerce st., Bridgeton
Pino, Anthony, 196 Irving av., Bridgeton
Ramsey, F. Muriel, 310 E. Pine st., Millville
Reeves, J. Franklin, 55 East av., Bridgeton
Sewall, Millard F., 195 E. Commerce st., Bridgeton
Sharp, Chas. E., Port Norris
Sheppard, A. G., 309 Broad st., Elmer
Sheppard, Frank R., 131 N. 3rd st., Millville
Sheppard, Muse A., 102 Main st., Elmer
Simkins, Raymond, 117 Broad st., Bridgeton
Thalheimer, Edward J., Vineland
Thomas, Geo. N., 712 Wood st., Vineland
Van Deusen, Edwin H., Vineland
Wainwright, Fredk. P., 87 Bank st., Bridgeton
Walker, Ada F. H., 635 Landis av., Vineland
Walker, H. Burton, 635 Landis av., Vineland
Ware, Carl N., Shiloh
Ware, Francis V., 223 N. 2nd st., Millville
Weithaase, Helen E., 803 Elmer st., Vineland

Whaland, Berta, 117 Atlantic st., Bridgeton
Wilson, Chas. W., 636 Wood st., Vineland
Wilson, Herbert H., 24 Bank st., Bridgeton
Winslow, John H., 27 S. Valley av., Vineland
Woodruff, Dare, 630 Landis av., Vineland

Honorary Members

Elmer, Matthew K., 3 Franklin st., Bridgeton

Number of active members and basis of representation, 55, Feb. 5, 1937.

ESSEX COUNTY (7)

Society organized June 4, 1816. Meets second Thursday of each month, October to May, inclusive. Annual Meeting is the second Thursday in May.

President, Ill, Edgar A., Newark

First Vice-President, Van Ness, H. Roy, Newark

Second Vice-President, Satchwell, Harry H., Newark

Secretary, Pinneo, Frank W., Newark

Treasurer, Rogers, Robert H., Newark

Reporter, Wood, E. LeRoy, Newark

Active Members

Abel, Arthur R., 188 S. Essex av., Orange
Abrams, Abram B., 668 Clinton av., Newark
*Adams, John K., 3 Prospect st., E. Orange
Adelman, Benj. B., 190 Clinton av., Newark
Agnew, Hobart McV., 27 S. Fullerton av., Montclair
Aikman, E. M., 30 Oak lane, Essex Fells
Albano, Jos, 535 N. 7th st., Newark
Alexander, Walter G., 48 Webster pl., Orange
Alford, Ralph I., 83 Park st., Montclair
Allan, James S., 144 Harrison st., E. Orange
Allen, Geo. H., 181 Roseville av., Newark
Allen, Raymond N., 144 Harrison st., E. Orange
Alling, Frederic A., 15 Washington st., Newark
Altman, Chas. D., 301 Highland av., Newark
Ambrose, Anthony, 71 Congress st., Newark
Antonius, Nicholas A., 27 W. Market st., Newark
Antopol, Wm. A., 201 Lyons av., Newark
Anuario, C. B., 283 So. Centre st., Orange
Applebaum, Irving L., 152 Clinton av., Newark
Areson, Wm. H., 153 Bellevue av., Upper Montclair
Ash, Samuel, 25 Johnson av., Newark
Asher, Maurice, 186 Clinton av,. Newark
Aszody, Paul, 340 Waverly av., Newark
Avidan, Maurice S., 30 Stratford pl., Newark
Bachmann, Wm., 87 Hillcrest ter., E. Orange
Baird, Thompson McD., 124 Grand pl., Arlington
Baker, Chas. F., 198 Clinton av., Newark
Baker, Maclyn, 638 Stuyvesant av., Irvington
Baldwin, Samuel H., 626 Clinton av., Newark
Banks, Winifred D., 6 N. Munn av., East Orange
Barkhorn, Chas. W., 223 Roseville av., Newark
Barkhorn, Henry C., 45 Johnson av., Newark
Barrett, Jos. F., 230 Parker av., Maplewood
Baum, Felix, 765 S. 10th st., Newark
Baum, Samuel, 10 Osborne ter., Newark
Bauman, Everett O., 30 Wilbur av., Newark
Becker, Fredk. W., 14 Clinton pl., Newark
Beling, Christopher A., 111 Clinton av., Newark
Beling, Christopher C., 111 Clinton av., Newark
Benedict, Alfred C., 121 Irvington av., So. Orange
Bengelsdorf, Aron, 29 Clinton pl., Newark
Bennett, Wm. F., Essex Mountain San., Verona
Berg, Samuel, 156 Roseville av., Newark
Berger, Wm. A., 346 Roseville av., Newark
Bergman, Meyer W., 31 Lincoln Park, Newark
Berman, H. Robert, 286 Roseville av., Newark
Bernhard, Wm. G., 226 Grove st., East Orange
Beyer, Othmar J., 42 Laurel av., Irvington
Bianchi, A. R., 228 So. 7th st., Newark
Bien, Frank A., 999 Clinton av., Irvington
Bigelow, Elizabeth F. F., 117 Irvington av., So. Or.
Bigelow, Nelson S., 117 Irvington av., So. Orange
Bingham, Arthur W., 144 Harrison st., E. Orange
Birdsall, Clarence A., 9 Smull av., Caldwell
Bissett, John V., 29 Hawthorne av., E. Orange
Blackburne, Geo., 490 Central av., Newark
Blaustein, Maurice L., 37 Hillside av., Newark
Blauvelt, Harold, 46 Parker av., Maplewood
Bleick, Theodore E., 61 Van Ness pl., Newark
Bleick, Wm. D., 583 Prospect av., Maplewood
Bleier, Louis, 89 Ferry st., Newark
Block, Marcus T., 177 Bloomfield av., Newark
Block, Max, 48 N. Fullerton av., Montclair
Bocchini, Jos. A., 366 S. 12th st., Newark
Bokor, Emery, 79 Shanley av., Newark
Bove, Joseph, 306 Lincoln av., Orange
Brackett, Elizabeth R., 371 Franklin av., Nutley
Bradford, Stella S., 16 Seymour st., Montclair
Bradshaw, John H., 27 High st., Orange
Brakeley, Elizabeth, 71 Myrtle av., Montclair
Braun, Gustav A., 391 Bergen st., Newark
Breitstadt, Chas. A., 563 Summer av., Newark
Brien, Wm. M., 449 Main st., Orange
Briggs, Henry, 16 Undercliff ter., W. Orange
Brim, Anne J. S., 74 S. Munn av., East Orange
Broadnax, Mary E., 83 Lincoln Park, Newark
Brodkin, Eva T., 365 Osborne ter., Newark
Brodkin, Henry A., 365 Osborn ter., Newark
Brooke, Chas. R., 1136 S. Broad st., Newark
Brotman, Morton M., 90 Avon av., Newark
Brown, Chester R., 22 Midland av., Arlington
Brown, Chester T., Prudential Insurance Co., New'k
Brown, Lewis W., 160 Roseville av., Newark
Brown, Richard J., 105 Ridgewood rd., S. Orange
Buckley, Jeremiah L., 666 Franklin av., Nutley
Bugbee, Fredk. C., 132 Sunset av., Verona
Bull, Louis M., 92 Heller Parkway, Newark
Bull, Robt. I., 531 W. Market st., Newark
Bull, Wm. J., 98 Park st., Montclair
*Bunn, Frank C., 30 Hilyer st., Orange
Burke, Stephen E., 212 First av., Newark
Burne, John J., 17 Gould av., Newark
Burns, Edward L., 269 Broad st., Newark
Busch, Herman, 38 Johnson av., Newark
Bush, Archer C., 40 Union st., Montclair
Butler, Eustace C., 249 Bloomfield av., Caldwell
Buvinger, Chas. W., 50 Washington st., E. Orange
Byck, Louis, 114 Lyons av., Newark
Caggiano, Anthony P., 137 Grove st., Montclair
Cahill, Laurence A., 361 Lafayette st., Newark
Caldwell, Julius A., 45 S. Mountain av., Montclair
Calvert, Wm. C., 210 Central av., Orange
*Campbell, H. B., 21 Court st., Newark
Camehe, Leo J., 250 Renner av., Newark
Cameron, Edwin A., 186 S. Burnett st., E. Orange
Campbell, Wm., 144 Harrison st., East Orange
Carbone, Francesco N., 157 Hunterdon st., Newark
Cardwell, Edgar P., 47 Central av., Newark
Carlucci, Angelo M., 83 Elizabeth av., Caldwell
Carman, Fletcher F., 31 Lincoln Park, Newark
Carrigan, Francis P., Jr., 228 Franklin av., Nutley
Casale, John B., 496 Highland av., Newark
Cater, Douglas A., 57 So. Harrison st., E. Orange
Cestone, Canio, 521 Pompton av., Cedar Grove
Chamberlain, Aims R., 30 Lenox pl., Maplewood

Champlin, Paul M., 43 S. Arlington av., E. Orange
Chapman, Robt. W., 835 Bergen st., Newark
Chattin, John F., 671 Broad st., Newark
Cherashore, Henry N., 363 Centre st., Nutley
Chiger, Alex. S., 621 High st., Newark
Chisholm, Gibbs, 14 Boston st., Newark
Chmelnik, Abraham G., 299 Clinton av., Newark
Clarken, Jos. A., 43 Lincoln Park, Newark
Claus, C. Hermann, 776 So. 19th st., Newark
Clayton, James O., 516 Broad st., Newark
Clement, Baxter L., 31 Lincoln Park, Newark
Coburn, John W., 111 N. Oraton Pkwy., E. Orange
Coe, Richard, 156 Clinton av., Newark
Coffin, Henry F., 433 Mt. Prospect av., Newark
Coghlan, Jasper, 17 Academy st., Newark
Cohen, I. Elvin, 561 Elizabeth av., Newark
Cohen, Maurice, 106 Valley rd., Montclair
Cohen, Max, 9 Franklin pl., No. Arlington
Cohen, Meyer J., 118 Johnson av., Newark
Cohen, Sidney L., 20 Avon av., Newark
Cohen, Sidney P., 512 Franklin av., Nutley
Cohn, Geo. M., 748 S. 10th st., Newark
Cohn, Hermann, 393 Clinton av., Newark
Cohn, Royal M., 740 Clinton av., Newark
Colsh, LeRoy L., 612 Ridgewood rd., Maplewood
Colton, Ethan T., Jr., 31 Park st., Montclair
Comando, Harry N., 690 Clinton av., Newark
Condon, John F., 686 Mt. Prospect av. Newark
Conlon, Philip J., 25 James st., Newark
Connamacker, Harold S., 671 Springfield av.,Newark
Connolly, John J., 212 W. Market st., Newark
Connoliy, Richard N., Newark City Hosp., Newark
Cook, Hugh F., 21 Roseville av., Newark
Cooke, Wm. H., 303 Main st., East Orange
Cooperman, Wm., 647 Market st., Newark
Cordasco, Peter, 24 Dodd st., Bloomfield
*Corwin, Theodore, 671 Broad st., Newark
Coughlan, Ella A., 10 Oakwood av., Orange
Coughlin, Frank J., 24 Beech st., Arlington
Cox, John C., 55 Woodland rd., Maplewood
Cox, Wm. W., 79 S. Fullerton av., Montclair
Crane, Chas. G., 78 Farley av., Newark
Crawford, Georgina L. U., 28 Carnegie av., E. Or.
Crecca, Anthony D., 76 Second st., Newark
Crecca, D. Wm., 111 Park av., Newark
Crossfield, Henry C., 144 Harrison st., E. Orange
Crystell, Edward H., 4 Hawthorne av., Nutley
Curtis, Elbert A., 65 Central av., Newark
D'Acunto, Pellegrino, 141 Mt. Prospect av., Newark
Dane, Chas., 61 Scotland rd., So. Orange
Dane, John, 61 Scotland rd., So. Orange
Danzis, Maximillian, 31 Lincoln Park, Newark
Davenport, Peter B., 764 S. Orange av., Newark
Davidson, Henry A., 31 Lincoln Park, Newark
Davidson, Louis L., 31 Lincoln Park, Newark
Davies, Geo. W., 35 Fairview av., Verona
Davis, Louis, 825 S. 10th st., Newark
Davis, Thos. C., 30 Old Short Hills rd., Millburn
DeFino, Felix J., 463 N. 7th st., Newark
Deignan, Wm. L., 257 Dodd st., East Orange
Del Deo, Nicholas V., 49 State st., Newark
Del Guercio, Olindo, 342 Clifton av., Newark
*Demarest, L. M., 226 S. Orange av., So. Orange
Denes, Oscar, 402 Centre st., Nutley
DePalma, Anthony F., 290 Central av., Orange
Derivaux, John A., 103 Clinton av., Newark
Deutel, Oscar R., 283 Franklin st., Bloomfield
De Vausney, Winfield S., 50 James st., Newark
De Vincentis, Henry, 285 Henry st., Orange
Devlin, Frank, 617 Broadway, Newark
Dias, Jos. L., 17 Lombardy st., Newark
Dieffenbach, Rich. H., 570 Mt. Prosp'ct av., Newark
Dinge, Ferdinand C., 67 S. Munn av., E. Orange
Dodd, Edward L., 157 Forest st., Belleville
Donahue, Wm. J., 71 So. 9th st., Newark
Donnelly, Robt. J., 208 W. Market st., Newark
Doremus, Widmer E., 375 Mt. Prospect av., Newark
Dorn, Elliott I., 267 Vassar av., Newark
Dowd, Ambrose F., 239 Broadway, Newark
Dranow, Paul, 233 Franklin av., Nutley
Dreskin, Jacob L., 172 Lyons av., Newark
DuBois, Morris G., 769 High st., Newark
Dulin, Everett V., 144 Harrison st., E. Orange
Dunn, Theodore B., 194 Broad st., Bloomfield
Eagleton, Wells P., 15 Lombardy st., Newark
Ebenfeld, Samuel W., 344 High st., Newark
Echikson, Jos. I., 845 S. 12th st., Newark
Edelen, James J., 280 S. Clinton st., East Orange
Eigen, Louis A., 511 Valley rd., W. Orange
Ein, Wm. B., 31 Lincoln Park, Newark
Eisenberg, David S., 31 Lincoln Park, Newark
Ellis, Arthur J., 282 Broad st., Newark
Ellis, Moury I., 177 S. Clinton st., E. Orange
Emerson, Linn, 310 Main st., Orange
Emmer, S. Wolfe, 31 Lincoln Park, Newark
Englander, Chas., 41 Hillside av., Newark
English, James R., 51 Cypress st., Newark
English, John T., 681 Stuyvesant av., Irvington
Epler, Don A., 45 Hillside av., Newark
Epstein, Harry B., 31 Lincoln Park, Newark
Erler, Eugene W., 360 Irving av., So. Orange
Ervin, Millard B., 572 Prospect st., Maplewood
Etheridge, Chas. H., 433 Prospect st., E. Orange
Evans, Chas. H., 144 Harrison st., East Orange
Evans, David P., 144 Harrison st., East Orange
Ewing, Harvey M., 31 Trinity pl., Montclair
Failing, Brayton E., 31 Lincoln Park, Newark
Fanburg, Sol J., 31 Lincoln Park, Newark
Farden, Jos. L., 342 Roseville av., Newark
Farr, Irving L., 214 Walnut st., Montclair
Fasano, Giovanni, 194 So. 7th st., Newark
Faughnan, Rose C., 97 High st., Passaic
Fechner, Julius, 362 Clinton av., Newark
Fein, Bernard S., 585 Elizabeth av., Newark
Fendrick, Edward, 91 Watson av., East Orange
Feneck, Chas. C., 510 Roma av., Phoenix, Ariz.
Ferguson, Wm. E., 22 James st., Newark
Fern, Samuel S., 122 Elizabeth av., Newark
Fewsmith, Jos. L., 120 Second av., Newark
Fine, M. James, 65 Girard pl., Newark
Finesilver, Edward M., 53 Lincoln Park, Newark
Fink, Irving E., 129 Lyons av., Newark
Finkel, Joshua, 368 Clinton av., Newark
Finkelstein, Abe S., 670 Clinton av., Newark
Finkler, Rita V. S., 35 Leslie st., Newark
Fischman, Harold H., 326 Avon av., Newark
Fitzpatrick, Edward F., 546 W. Market st., Newark
Flanagan, John J., 47 Central av., Newark
Flower, Morris A., 39 Lincoln Park, Newark
Flynn, Edward A., 161 Washington av., Belleville
Ford, Theodore R., 144 Harrison st., East Orange
Forsyth, Kenneth C., 611 Mt. Prospect av., Newark
Fort, J. Irving, 306 Roseville av., Newark
Forte, Frank S., 318 Roseville av., Newark
Fost, Wm. H., 107 Franklin st., Belleville
Foster, Herbert W., 2 Erwin Park, Montclair
Foster, Wm. S., 233 Mt. Prospect av., Newark
Fowler, Royale H., 744 Broad st., Newark
Freeman, Geo. C., 1 Lenox pl., Maplewood
Freeman, Richard D., 103 Scotland rd., So. Orange
Freinkel, Jacob, 2 Hillside av., Newark
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Froelich, Jos. C., 74 Ingraham pl., Newark
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Furman, Benj. A., 31 Roseville av., Newark
Furst, Nathan J., 190 Johnson av., Newark
Ganley, Arthur J., 390 Park av., E. Orange
Ganot, Frank I., 639 Ridge st., Newark

Gantz, Emma O., 215 N. Grove st., East Orange
Gardam, Jos. W., 16 Longfellow av., Newark
Gardner, Kenneth E., 1 Park pl., Bloomfield
Gauch, Wm., 177 Elwood av., Newark
Gelber, Louis J., 550 Mt. Prospect av., Newark
Gennell, Ernest, 298 Parker st., Newark
George, Melbourne E. W., 744 Broad st., Newark
Gerard, Patrick D., 364 Roseville av., Newark
Gershenfeld, David B., 20 Hillside av., Newark
Gifford, Wm. R., 247 Park av., East Orange
Gilman, Chas. M. B., 59 Seely av., Arlington
Glass, Oscar, 838 S. 12th st., Newark
Glass, Wm. H., 144 Harrison st., East Orange
Godfrey, Alan O., 220 Roseville av., Newark
Goffman, Emanuel, 316 Claremont av., Montclair
Goldberg, Harold H., 814 S. 10th st., Newark
Goldberg, Louis E., 31 Lincoln Park, Newark
Goldberg, Samuel A., 169 Gregory av., W. Orange
Goldberg, Samuel M., 353 Washington av., Bellev'le
Golden, Clement H., 347 16th av., Irvington
Goldman, I. M., 896 S. 16th st., Newark
Goldstein, Henry Z., 31 Lincoln Park, Newark
Goldstein, Samuel M., 40 Johnson av., Newark
Goldstein, Wm. H., 632 Belgrove dr., Arlington
Goodfellow, Gordon P., 196 Prospect st., E. Orange
Gordon, Abraham J., 273 Roseville av., Newark
Grady, Wm. F., 42 N. Fullerton av., Montclair
Graham, Richard B., 90 Midland av., Arlington
Grant, Wm. F., 309 Roseville av., Newark
Gray, John W., 142 Clinton av., Newark
Greenberg, Samuel, 46 Johnson av., Newark
Greenfield, Bernard H., 691 Clinton av., Newark
Gregorius, Ralph F., 120 Irvington av., So. Orange
Gregory, Mildred G., 64 N. 9th st., Newark
Greifinger, Marcus H., 200 Ferry st., Newark
Griffin, Guy B., 197 S. Centre st., Orange
Griffith, Roy, 909 Broad st., Newark
Grossblatt, Philip, 70 Baldwin av., Newark
Guthrie, Wilson G., 300 Summer av., Newark
Gutowski, Walter T., 104 Grove ter., Irvington
*Hagerty, John F., 212 W. Market st., Newark
Hagney, Fredk. W., 669 Elizabeth av., Newark
Hahn, Katherine B., 372 Thornden st., So. Orange
Hahn, Wm. H., 15 Lombardy st., Newark
Haley, Paul W., 781 Sanford av., Newark
Halprin, Harry, 8 Washburn pl., Caldwell
Halsey, Levi W., 61 Church st., Montclair
Hanan, James T., 11 The Crescent, Montclair
Hantman, Harold, 190 Clinton av., Newark
Harden, Albert Scott, 510 W. Market st., Newark
Harhen, Geo. E., 22 Brookside av., Caldwell
*Harris, Harry B., Orange
*Hart, Hugh, Mt. Prospect st., Newark
Harvey, Thos. W., 59 Main st., Orange
Harvey, Thos. W., Jr., 59 Main st., Orange
Hasney, Fredk. A., 292 Main st., W. Orange
Hauck, Lydia R. B., 644 Stuyvesant av., Irvington
Hauck, Wm. H., 644 Stuyvesant av., Irvington
Haussling, Francis R., 661 High st., Newark
Hawkes, E. Zeh., 84 Washington st., Newark
Hawkes, Stuart Z., 84 Washington st., Newark
Hayes, Gerald W., 86 Hawthorne av., E. Orange
Heath, Louanna, 20 Fairmount av., Newark
Heineken, Theodore S., 17 Park pl., Bloomfield
Heller, Nathan B., 31 Lincoln Park, Newark
Henle, Carye-Belle, 671 Springfield av., Newark
Henshaw, Geo. R., 49 Park st., Montclair
Hermann, John H., 197 So. Centre st., Orange
Herndon, Lewis S., 33 Johnson av., Newark
Hersh, David H., 658 Springfield av., Newark
Hewson, Geo. F., 21 Roseville av., Newark
Hexamer, Fred, 50 Lyons av., Newark
Heyman, Arthur, 79 Baldwin av., Newark
Hicks, Alfred M., 65 No. Fullerton av., Montclair
Hicks, Wm. H., 46 Milford av., Newark
Hill, Robt. H., 332 Park av., Newark
Hilton, Clarence O., 556 N. 7th st., Newark
Hobart, Richard T., 454 Park st., Upper Montclair
*Holden, Edgar J., 217 Broadway, Newark
Holland, Geo. A., 364 Clinton av., Newark
Holler, Henry G., 234 Montclair av., Newark
Holmes, Geo. J., 17 Elizabeth av., Newark
Horland, Aaron H., 24 Stengel av., Newark
Horn, Max, 94 Lyons av., Newark
Horsford, Fredk. C., 305 Broadway, Newark
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Hubbard, Fayette E., 65 Church st., Montclair
Hubbard, Robt. Y., 12 Myrtle av., Irvington
Huber, Wm. H., 15 Salem st., Newark
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Hulett, Albert G., 20 Hawthorne av., E. Orange
Humphries, Robt. E., 637 Central av., E. Orange
Hurff, Jos. W., 86 Washington st., Newark
Husserl, Siegfried, 777 Clinton av., Newark
Hymowitz, Ben, 56 W. Runyon st., Newark
Ill, Carl H., 188 Clinton av., Newark
Ill, Chas. L., 188 Clinton av., Newark
Ill, Edgar A., 1004 Broad st., Newark
Ill, Edward J., 1004 Broad st., Newark
Ill, Herbert M., 188 Clinton av., Newark
Inge, Theo. R., 336 Halsted st., East Orange
Irwin, James R., 330 Washington av., Belleville
Israeloff, Howard H., 1044 Clinton av., Irvington
Jackson, Albert F., 225 Hillside av., Nutley
James, Bart M., 31 Lincoln Park, Newark
James, Wm. L., 31 Lincoln Park, Newark
Jaso, James V. D., 274 Littleton av., Newark
Jedel, Meyer, 125 4th st., Newark
Jennings, Robt. E., 143 Park st., E. Orange
Jessurun, Samuel H., 613 High st., Newark
Jones, Edward C., 183 Grove st., Montclair
Jonitz, Robt., 157 So. Grove st., East Orange
Judge, John F., 33 Hazelwood av., Newark
Just, Francis, 564 High st., Newark
Kaderabek, Erwin J., 144 Harrison st., E. Orange
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Kalb, Samuel W., 416 Clinton pl., Newark
Kalter, Geo. E., 640 Prospect st., Maplewood
Kaplan, S. Bernard, 860 S. 11th st., Newark
Katzin, Eugene M., 50 Baldwin av., Newark
Kaufman, Jerome G., 299 Clinton av., Newark
Kaufman, Michael J., 103 Lyons av., Newark
Kavanaugh, Daniel E., 217 Broadway, Newark
Kearney, Edward P. J., 26 Forest st., Montclair
Keim, W. F., 25 Roseville av., Newark
Keller, Paul, 299 Clinton av., Newark
Keller, Sidney C., 31 Lincoln Park, Newark
Kennedy, Wm. McL., Essex Mountain San., Verona
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Kerns, Francis J., 526 W. Market st., Newark
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Kessler, Henry B., 666 Clinton av., Newark
Kessler, Henry H., 53 Lincoln Park, Newark
Kiley, John E., 31 Lincoln Park, Newark
Kirkby, Cyril S., 98 Broad st., Bloomfield
Kirkman, Leroy G., 176 Roseville av., Newark
Kirkwood, Allan S., 53 Union st., Montclair
Klein, Edward C., 209 Littleton av., Newark
Kleinman, Maurice, 198 Avon av., Newark
Klenk, Jos. P., 328 Belleville av., Bloomfield
Kolodin, Abraham, 146 Franklin st., Bloomfield
Kraemer, Manfred, 31 Lincoln Park, Newark
Kraker, David Aron, 31 Lincoln Park, Newark
Krone, Wm. F., 31 Lincoln Park, Newark
Kruger, Wm., 31 Lincoln Park, Newark
Kummel, Max, 31 Lincoln Park, Newark

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Lane, Frank B., 98 Prospect st., East Orange
LeBel, Louis J. B., 165 Grant av., Nutley
Lee, John J., 66 Central av., Orange
Lee, Stephen G., 55 Halsted st., East Orange
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Levin, Jos., 831 S. 13th st., Newark
Levine, Edward P., 86 Clinton av., Newark
Levinson, Louis J., 18 Stratford pl., Newark
Levitt, Jesse N., 26 Clinton pl., Newark
Levy, Julius, 202 Osborne ter., Newark
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Lovell, John F., 1011 Clinton av., Irvington
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McVay, Edward A., 234 Lafayette st., Newark
Maas, Max A., 329 Clinton av., Newark
Mabey, J. Corwin, Clarem't & Midl'd avs., Montcl'r
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MacArthur, Clymont, 219 Roseville av., Newark
MacDonald, Wentworth S., 56 Church st., Montcl'r
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Magovern, Thos. F., 226 S. Orange av., So. Orange
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Marquis, Wm. J., 198 Clinton av., Newark
Martin, Wm. P., 25 Holland rd., So. Orange
Martinetti, Carlo D., 311 Central av., Orange
Martland, Harrison S., 180 Clinton av., Newark
Martucci, Louis, 192 Mt. Prospect av., Newark
Massengill, Fulton, 125 Harrison st., East Orange
Masterson, John F., 98 Myrtle av., Irvington
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Matheke, Otto G., 328 Sussex av., Newark
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Mick, Edwin C., 46 S. Burnett st., East Orange
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Minier, Carl L., 25 N. Harrison st., East Orange
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Mintz, Abraham, 94 Shanley av., Newark
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Moeckel, Clarence W., 63 S. Fullerton av., Montclair
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Moore, John D., 6 Washington st., Bloomfield
Moretti, John J., 576 S. Clinton av., East Orange
Morgan, Browne, 260 Liberty st., Bloomfield
Morris, Clement, 511 Broadway, Newark
Morrison, Caldwell, 379 7th av., Newark
Morrison, J. Bennett, 66 Milford av., Newark
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Mount, Walter B., 21 Plymouth st., Montclair
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Nacca, Carl A., 86 N. Essex av., Orange
Nagler, Benedict, 75 Shephard av., Newark
Nappi, Pasquale E., 215 Mt. Prospect av., Newark
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O'Connor, Michael J., 98 Shanley av., Newark
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Olini, Jos. J., 30 W. Market st., Newark
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Orton, Henry B., 24 Commerce st., Newark
Paddock, Royce, 965 Broad st., Newark
Palmer, Gideon H., 28 Winans st., East Orange
Palmer, Henry S., 275 Mulberry st., Newark
Panitch, Wm., 356 Belmont av., Newark
Pannell, Walter Leo, 25 Prospect st., E. Orange
Pannullo, John N. P., 266 Van Buren st., Newark
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Parisi, Anthony, 150 Hunterdon st., Newark
Parker, John E., 144 Harrison st., East Orange
Parsonnet, Eugene V., 31 Lincoln Park, Newark
Pascall, Thos. M., 197 Lincoln av., Newark
Paul, Geo. A., 788 Lyons av., Irvington
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Pendexter, Sidney E., 11 S. Arlington av., E. Orange
Pennington, Alfred W., 398 N. Maple av., Newark
Perham, Bertram S., 199 Lorraine av., Up. Montcl'r
Petry, Wm., 109 Treacy av., Newark
Phillips. Algernon A., 13 Howard st., Newark
Pilch, Arthur G., 1 Willard av., Bloomfield
Pilloni, Louis, 91 Beach st., Bloomfield
Pinneo, Frank W., 439 Mt. Prospect av., Newark
Pizzi, Francis W., 205 Park av., Orange
Plain, Irving H., 2 Stratford pl., Newark

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Plante, Amos A., 437 Ridgewood rd., Maplewood
Pois, John, 52 Pillot pl., W. Orange
*Polevski, Jacob B., 682 High st., Newark
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Polow, Benj., 24 Johnson av., Newark
Pomeranz, Raphael, 31 Lincoln Park, Newark
Potter, Raymond T., 144 Harrison st., E. Orange
Prestifilippo, Silvestro, 61 Ardsley rd., Montclair
Preston, Perry B., 12 Palm st., Newark
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Proctor, Jesse E., 15 N. 13th st., Newark
Pudney, Wm. K., 31 Trinity pl., Montclair
Quad, Clifford W., 52 Northfield av., W. Orange
Quinby, Wm. O'G., 14 James st., Newark
Rado, Wm., 190 Clinton av., Newark
Rados, Andrew, 31 Lincoln Park, Newark
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Randall, Chas. H., 50 3rd av., Newark
Ranson, Briscoe B., 601 Ridgewood av., Maplewood
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*Rathgeber, Wm. M., 249 Roseville av., Newark
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Reich, Abraham L., 83 Lyons av., Newark
Reich, Henry, 31 Lincoln Park, Newark
Reilly, John V., 472 Sanford av., Newark
Reinfeld, Abraham G., 354 Clinton av., Newark
Reissman, Erwin, 31 Lincoln Park, Newark
Reitter, Geo. S., 144 Harrison st., E. Orange
Renzulli, Francesco, 228 S. 7th st., Newark
RePass, Paul E., 144 Harrison st., E. Orange
Rettig, Isidor L., 36 Milford av., Newark
Ribbans, Robt. G., 63 Central av., Newark
Rich, Chas., 191 Littleton av., Newark
Richardson, Arthur H., 60 Orange rd., Montclair
Riggins, Edwin N., 161 N. Arlington av., E. Orange
Ripley, Chas. D., Point Pleasant Beach
Ripley, Edward W., 7 Trinity pl., Montclair
Rizzolo, Edward M., 523 Union av., Belleville
Robbin, Lewis, 18 Clinton pl., Newark
Robbins, Chas. M., 31 Lincoln Park, Newark
Roberts, Allison H., 24 So. 9th st., Newark
Roberts, D. C., 158 S. Harrison st., E. Orange
Roberts, Frank A., 11 Park av., Caldwell
Roberts, Wm. A., 11 Park av., Caldwell
Robinson, Louis H., 31 Lincoln Park, Newark
Rocco, Frank, 729 Summer av., Newark
Roeber, Wm. J., 21 Nesbit ter., Irvington
Rogers, Harry, 144 Harrison st., E. Orange
Rogers, Richard M., 1 Wallace st., Newark
Rogers, Robt. H., 49 9th av., Newark
Roh, Robt. F., 671 Broad st., Newark
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Rose, Mary E. D., 453 Park av., Orange
Rosenberg, L. Chas., 11 Murray st., Newark
Roth, Oswald H., 210 Littleton av., Newark
Roth, Samuel R., 31 Lincoln Park, Newark
Rothenberg, Samuel, 31 Lincoln Park, Newark
Rothhouse, Burnet, 19 Lincoln Park, Newark
Rothschild, Daniel L., 585 Elizabeth av., Newark
Rothseid, Abraham, 59 Avon av., Newark
Rothstein, Isadore B., 16 Lyons av., Newark
Rubin, Abraham A., 379 Washington av., Belleville
Rubinow, Saul M., 755 High st., Newark
Runyan, Wm. J., 106 Broad st., Bloomfield
Russomanno, Raymond L., 227 Clifton av., Newark
Salomon, Kurt, 732 Lyons av., Irvington
Samson, Norman D., 281 Kearny av., Kearny
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Saslow, Benj. I., 680 Clinton av., Newark
Sasso, Albert, 99 Parker st., Newark
Satchwell, Harry H., 169 Roseville av., Newark
Sax, Max. T., 84 Grove st., Bloomfield
Sbarra, Francesco C. N., 531 W. Market st., Newark
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Schaefer, Eugene P., 12 Harrison pl., Irvington
Schaffer, Nathan, 172 S. Arlington av., E. Orange
Schectman, Vera, 385 Osborne ter., Newark
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Schiller, Nicholas, 29 Girard pl., Newark
Schimmelpfennig, R. D., 65 N. Fullerton av., M'tcl'r
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Schneider, Louis, 874 S. 13th st., Newark
Schoenau, Carl W., 1255 Broad st., Bloomfield
Schramm, Jos. A., 23 Darcy st., Newark
Schreck, Harry, 192 Roseville av., Newark
Schulsinger, Samuel, 80 Clinton av., Newark
Schulte, Herbert A., 701 Clinton av., Newark
Schultz, Anna R., 207 Summer av., Newark
Schurman, Francis H. C., 14 Smull av., Caldwell
Scott, Robt. Hunter, 205 Roseville av., Newark
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Scudder, Frank D., 65 N. Fullerton av., Montclair
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*Seidler, Wm. F., Rosemere pl., Belleville
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Seifert, Edwin A., 247 Claremont av., Montclair
Sellers, Robt. R., 19 Chestnut st., Newark
Shannon, Anne L. M., 66 S. Fullerton av., Montclair
Shannon, James B., 66 S. Fullerton av,. Montclair
Shapiro, Louis, 146 Broad st., Newark
Shaul, Fredk. G., 10 Washington st., Bloomfield
Sheehan, Daniel C., 12 Cliff st., Newark
Sherman, Allton L., 485 Park av., Orange
Sherman, Anthony R., 671 Broad st., Newark
Sherman, Arthur E., 25 Prospect st., E. Orange
Sherman, Elbert S., 671 Broad st., Newark
Shill, Benj., 234 Osborne ter., Newark
Shor, David M., 32 S. Munn av., E. Orange
Siegel, Jacob W., 96 S. 10th st., Newark
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Silverstein, Benj. J., 32 Hillside av., Newark
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Singer, Max, 147 Johnson av., Newark
Sisson, Nelson W., 144 Harrison st., E. Orange
Skwirsky, Jos., 170 Hawthorne av., Newark
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Staehle, Richard H., 34 Lyons av., Newark
Stahl, Alfred, 55 Lincoln Park, Newark
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Stevens, J. Thompson, 55 Park st., Montclair
Stewart, Robt. G., 79 Midland av., Montclair
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Straub, Herbert H., 242 Springdale av., E. Orange

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Taylor, Geo. H., 144 Harrison st., E. Orange
Teeter, Chas. E., 418 Orange st., Newark
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Thomas John H., 270 Lenox av., So. Orange
Thomison, Harry E., 605 Broad st., Newark
Thompson, Arthur F., 144 Harrison st., E. Orange
Thompson, Austin B., 479 Highland av., Orange
Thomson, Carroll S., Fair Oaks San., Summit
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Tillis, Herman H., 11 Bergen st., Newark
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Tobey, Franklin J., 11 Hazelwood av., Newark
Tomasulo, Gennaro L., 225 Clifton av., Newark
Tomec, Richard F., 42 Melrose pl., Montclair
Toye, John E., 90 Midland av., Arlington
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Wilkes, Arthur C., 36 Osborne ter., Newark
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Willson, James H., 144 Harrison st., E. Orange
Wintsch, Carl Herman, 841 S. 12th st., Newark
Wolfe, Jacob S., 44 Watsessing av., Bloomfield
Wolfe, James C., 56 Church st., Montclair
Wolfe, Wm. W., 383 Mulberry st., Newark
Wood, E. LeRoy, 160 Roseville av., Newark
Woolf, Bernhardt H., 15 Hedden ter., Newark
Wort, Fredk. J., 1080 Broad st., Newark
Wrensch, Alexander E., 79 Valley rd., Montclair
Wyker, Arthur W., 229 Liberty av., Bloomfield
Yadkowsky, Emanuel, 637 High st., Newark
Yagoda, Asher, 88 Clinton av., Newark
Yates, Glen L., 330 Washington av., Belleville
Young, Irving H., 1203 Clinton av., Irvington
Zehnder, A. Charles, 188 Roseville av., Newark
Zimmer, Wm., 83 Vassar av., Newark
Zimmerman, Coler, 82 No. Arlington av., E. Orange
Zweibel, Leonard, 885 S. 13th st., Newark
Zweigel, Isidore, 889 S. Orange av., E. Orange

Associate Members

Alcamo, John H., 215 Littleton av., Newark
Anderson, Robt. C., 196 Smith st., Newark
Baiocchi, Pascal J., 203 Hunterdon st., Newark
Barnard, F. G., 22 Plymouth st., Montclair
Biunno, Anthony J., 53 Finlay pl., Newark
Borsher, Irving P., 255 Broad st., Bloomfield
Calisibetta, C. J., 37 Longfellow av., Newark
Caputo, Anthony R., 15 DeWitt av., Belleville
Carroll, Wilfred, 56 Goodwin av., Newark
Chamberlain, P. R., 30 Lenox pl., Maplewood
Cornish, C. H., 673 Prospect st., Maplewood
Della Fera, Lucien F., 206 First av., Newark
Denberg, Hyman S., 307 Peshine av., Newark
DeVivo, John A., 225 Littleton av., Newark
DiNorcia, Jos., 451 N. 7th st., Newark
Eichler, B. B., 159 Bellevue av., Upper. Montclair
Fenichel, Benj., 30 Peck av., Newark
Feurer, Joseph A., 654 Elm st., Arlington
Fratantuno, Michael J., 152 W. Market st., Newark
Gamba, Joseph, 345 Fairmount av., Newark
Gelb, Jerome, 84 W. Alpine st., Newark
Giannetti, Ernest D., 180 Glen Ridge av., Montclair
Gibbons, A. Leslie, 319 S. 12th st., Newark
Glazier, Jesse T., 670 Sanford av., Irvington
Greenfield, L. S., 691 Clinton av., Newark
Greenwald, T. L., 1 Llewellyn pl., W. Orange
Gross, Isadore, 60 Lakeside av., Verona
Grunt, Louis, 404 Bergen st., Newark
Gulick, Jas. B., 144 S. Harrison st., E. Orange
Gullard, E. G., 205 Alexander av., Up. Montclair
Halpern, M. M., 493 Central av., Newark
Hamilton, R. G., 92 Main st., Orange
Harden, Albert S., Jr., 536 Ridgewood av., Maplew'd
Harvey, R., 92 Forts st., Kearny
Heller, Abraham R., 10 Kearny av., Kearny
Hennig, Paul F., 688 Stuyvesant av., Irvington
Hooton, Thomas G., 56 Church st., Montclair
Jacobs, Wm., 360 Broad st., Newark
Klein, Andrew J. V., 209 Littleton av., Newark
Kleinberger, H. H., 59 Main st., Millburn
Kline, Geo. L., 146 N. Grove st., E. Orange
Kohn, L., 301 S. Orange av., South Orange
Lawless, Edward T., 83 Warrington pl., E. Orange
Lifland, B. D., 62 Farley av., Newark
Lilien, Bernard B., 730 Lyons av., Irvington
MacArt, James H., 74 S. Munn av., E. Orange
Marcus, Donald, 640 Stuyvesant av., Irvington
Margolis, Alfred, 28 West End av., Newark
Mason, V. A., 100 Chestnut st., East Orange
McIntyre, Harold E., 144 Harrison st., E. Orange
Miller, Ralph, 55 Wilbur av., Newark
Mullin, Eugene F., 515 Sanford av., Newark
Nadel, Charles I., 151 Boulevard, Bayonne
O'Grady, Michael J., 299 Broadway, Newark
Pattyson, R. A., 144 Harrison st., East Orange
Payne, Guy, Jr., 9 S. Prospect st., Verona
Reinhardt, W. I., 298 N. Arlington av., East Orange
Robertson, E. S., 22 Harding ter., Kearny
Roles, E. W., 25 N. Harrison st., East Orange
Romano, P. J., 203 S. Essex av., Orange

Rosen, Chas. D., 27 Clonavor rd., W. Orange
Rubino, Nicholas M., 67 N. 4th st., Newark
Santoro, Thomas A., 272 S. 8th st., Newark
Schotland, C. E., 41 Leslie st., Newark
Schaffer, Barney, 252 Washington av., Belleville
Sellito, A. M., 268 Valley rd., South Orange
Seidman, Joshua I., 31 Lincoln Park, Newark
Shaner, Ralph D., 94 Hillside av., Nutley
Shaw, John T., 127 Scheerer av., Newark
Shreehan, Huber F., 382 Summer av., Newark
Shulman, Murray W., 916 S. 20th st., Newark
Smith, Christopher A., 6 Park st., Roseland
Statman, Arthur J., 337 Hawthorne av., Newark
Strack, Vincent J., 286 Charlton av., S. Orange
Suesserman, Henry, 389 Lyons av., Newark
Sutton, Harold L., 44 Walnut st., Newark
Torppey, John J., 124 Oakland ter., Newark
Ulverstad, L. E., 147 Halsted st., East Orange
Waldron, R. E., 317 Roseville av., Newark
Waterman, S. M., 364 Clinton av., Newark
Weinstein, Francis S., 189 16th av., Newark
Wolfe, R. E., 47 Lawrence av., West Orange
Wright, R. E., 173 Park av., East Orange
Zybulewski, E. A., 410 Bergen st., Newark

Resigned

Terriberry, W. K.

Transferred

Doremus, Widmer E., to Cumberland County, N. H.
Ford, Theo. R., from Union County Medical So.
Ray, Erwin L., from New York County Medical So.
Wurtz, Margaret, from Bergen County

Number of active members and basis of representation, 788, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937.

GLOUCESTER COUNTY (8)

Society organized December, 1818. Regular meetings on the third Thursday of each month, except June, July and August. Annual Meeting in May. Annual Social Session in October.

President, Lummis, M. F. Pitman

Vice-President, Wood, Oran A., Paulsboro

Secretary, Downs, E. E., Woodbury

Treasurer, Weems, Don B., Wenonah

Reporter, Diverty, H. B., Woodbury

Active Members

*Aschraft, Samuel, Mullical Hill
Barrows, Victor I., 316 N. Broadway, Pitman
Brewer, Wm., 34 Cooper st., Woodbury
Burkett, John P. 43 Curtis av., Woodbury
Burkett, Wendell J., 16 W. Holly av., Pitman
*Campbell, Duncan, Woodbury
Campo, A. Guy, Westville
Carpenter, Wm. H., 39 Aberdeen pl., Woodbury
Crain, Wm. E., Woodbury
Diverty, Henry B., 38 Cooper st., Woodbury
Downs, Elwood E., 7 S. Childs st., Woodbury
Fisler, Chas. F., 140 Maple st., Clayton
Fooder, Horace M., 110 Main st., Williamstown
Gairdner, Thos. M., 319 Broad st., Gibbstown
Gillis, Alfred G., 37 W. High st., Clayton
Harris, Wm. G., Mullica Hill
Hillegass, Eugene Z., Mantua
Hollinshed, Ralph K., 351 Broadway, Westville
Hughes, Joseph F., 116 N. Broad st., Woodbury
Knight, Isaac W., Pitman
Livengood, Baxter A., 406 Second st., Swedeboro
Lummis, Marshall F., 10 S. Broadway, Pitman
Moore, Ralph L., 509 N. Broad st., Woodbury
Nelson, Harry, 36 Lupton st., Woodbury
Patterson, Isaac N., 230 Broadway, Westville
Pedrick, Wm. W., 11 West st., Glassboro
Pegau, Paul M., 246 Briar Hill Lane, Woodbury
Rhoads, S. Creadick, 104 Station av., Westville
Rogers, Dorothy M., 50 Cooper st., Woodbury
Ruttenberg, Louis, Union st., Mantua
Sheets, Cecil C., 213 W. Broad st., Paulsboro
Sherman, Fuller G., 53 Newton av., Woodbury
Sinexon, Henry L., 36 W. Broad st., Paulsboro
Sooy, Leslie T., 818 S. Broadway, Pitman
Stewart, Irving J., 529 Kings Highway, Swedesboro
Ulmer, Chester I., 431 W. Broad st., Gibbstown
Underwood, James H., 509 N. Broad st., Woodbury
Venturo, Ralph C., 101 S. Main st., Glassboro
Weems, Don B., 105 E. Mantua av., Wenonah
Wood, Oran A., 128 W. Broad st., Paulsboro
Wright, Herman W., 818 S. Broadway, Pitman

Number of active members and basis of representation 39, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937

HUDSON COUNTY (9)

Society Organized October 11, 1851. Meets first Tuesday evening of each month, October to May, inclusive. If a legal holiday, the meeting to be held on the next day. Annual Meeting in May.

President, Evans, J. Lawrence, Woodcliff

Vice-President, Williamson, W. L., Bayonne

Secretary, Brennock, Thomas McG., Jersey City

Treasurer, Spence, Henry, Jersey City

Reporter, Connell, John N., Jersey City

Active Members

Adams, Samuel, 29 Highland av., Jersey City
Africano, Julius V., 4246 Hudson Blvd., Union City
Agolia, Michael W., 1347 Boulevard, W. New York
Ainsley, Harry B, 246 Union st., Jersey City
Alexander, Hugo, 928 Hudson st., Hoboken
Allen, Isaac L., 521 Palisade av., Union City
Alpert, Edward, 661 Jersey av., Jersey City
Alter, Nicholas M., 410 Fairmount av., Jersey City
Amdur, Louis A., 834 West Side av., Jersey City
Angelo, Jos. A., 1190 Paterson Plank rd., Secaucus
Aria, Michael H., 31 Glenwood av., Jersey City
Arlitz, Wm. J., 107 Newark st., Hoboken
Arndt, Frank Roy, 217 29th st., Woodcliff
Ash, Arthur F., 710 Boulevard E., Weehawken
Atwell, David R., 920 Hudson st., Hoboken
Auricmma, Michele, 419 Adams st., Hoboken
Axford, Wm. H., Chester
Baechler, Jules, 439 16th st., West New York
Bahnson, Conrad M., 170 Bowers st., Jersey City

Bailyn, Emanuel, 331 16th st., West New York
Ballinger, Reeve L., 759 Kearny av., Arlington
Banach, Leon, 2747 Hudson Blvd., Jersey City
Barbarito, Wm. N., 135 Bentley av., Jersey City
Barishaw, Samuel B., 5 Bentley av., Jersey City
Barrett, Arthur F., 855 Montgomery st., Jersey City
Behrens, Herman H. E., 312 Webster av., Jer. City
Ben-Asher, Solomon, 260 Bergen av., Jersey City
Bender, Max. 327 23rd st., Union City
Benjamin, Harold C., 59 Crescent av., Jersey City
Berlin, Jos. I., 9 Gifford av., Jersey City
Bitten, Robt. M., 33 Romaine av., Jersey City
Bonanno, Peter J., 500 35th st., No. Bergen
Bookrajian, Edw. N., 5459 Hudson Blvd., N. Bergen
Borrone, Milton G., 2695 Boulevard, Jersey City
Borshaw, Hyman, 108 Bentley av., Jersey City
Bortone, Frank, 2765 Hudson Blvd., Jersey City
Boselli, Emile H., 614 15th st., Union City
Botti, John A., 236 Summit av., Jersey City
Bowyer, Franklin F., 50 Gifford av., Jersey City
Brady, Thos. S., 678 Avenue C, Bayonne
Brady, Wm. A., 403 46th st., Union City
Brandenburg, L. W. A., 4260 Hudson Blvd., Union C.
Brauer, Selig L., 234 Bergen av., Jersey City
Braunstein, Sigmund C., 424 13th st., W. New York
Braunstein, Wm. P., 831 Blvd. E., Weehawken
Brennock, Thos. McG., 3 Webster av., Jersey City
Brick, Geo. J., 43 Cottage st., Jersey City
Brooke, Wm. W., 915 Avenue C, Bayonne
Brophy, Francis X., 55 Gifford av., Jersey City
Brozdowski, John J., 554½ Jersey av., Jersey City
Bruder, Andrew J., 344 Fairmount av., Jersey City
Butler, Vincent deP., 33 Bentley av., Jersey City
Callery, Wm. T., 10 Columbia ter., Weehawken
Cannon, Edward A., 5360 Hudson Blvd., N. Bergen
Caridi, Salvatore, 465 Bergenline av., W. New York
Carr, Mary B., 1 Astor pl., Jersey City
Chapman, Ellis J., 203 Danforth av., Jersey City
Chayes, Sydney, 980 Ave. C, Bayonne
Christian, Henry A., 111 Fairview av., Jersey City
Clark, Chas. C., 461 New York av., Union City
Cobham, James L., 78 Brinkerhoff st., Jersey City
Cohen, Herman, 489 Jersey av., Jersey City
Cohen, Herman N., 714 Park av., Hoboken
Cohen, Samuel A., 112 Mercer st., Jersey City
Comora, Herman C., 317 16th st., West New York
Connell, Emmet J., 2227 Hudson Blvd., Jersey City
Connell, John P., 977 Summit av., Jersey City
Connell, John N., 26 Carlton av., Jersey City
Conty, Anthony J., 318 48th st., Union City
Cosgrove, Samuel A., 254 Union st., Jersey City
Coughlin, John P., 43 Arlington av., Jersey City
Cropper, C. W., Clarkton Country Club, Nyack, N.Y.
Crowley, Leo F., 148 Belmont av., Jersey City
Culver, Geo. M., 25 Glenwood av., Jersey City
Culver, Samuel H., 75 Magnolia av., Jersey City
Cupaiuoli, Richard A., 21 31st st., No. Bergen
Curtis, Grant P., 312 36th st., Union City
D'Acierno, Pellegrino A., 346 Palisade av., Union C.
Daly, Edmund J., 921 Bergen av., Jersey City
Davey, Thos. N., 41 W. 33rd st., Bayonne
DeFuccio, Chas. P., 47 Glenwood av., Jersey City
DeFusco, Gaetano T., 330 Newark av., Jersey City
DeMeritt, Chas. L., 1225 Bloomfield st., Hoboken
Dershimer, Fredk. W., 546 Bergen av., Jersey City
Dillingham, Willis I., 431 15th st., West New York
Dodson, Louis W., 592 Jersey av., Jersey City
Dolganos, Moses, 268 Palisade av., Jersey City
Donnelly, Jos. F., 1 Madison av., Jersey City
Donohoe, Lucius F., 140 W. 8th st., Bayonne
Doody, Wm. M., 19 Bentley av., Jersey City
Doran, Ralph J., 200 11th st., Hoboken
Doran, Wm. G., 921 Bergen av., Jersey City
Dougherty, Daniel C., 1006 Garden st., Hoboken
Draesel, Chas., 5681 Hudson Blvd., No. Bergen
Duckett, Warren J., 21 Carlton av., Jersey City
Dukes, Howard R., 220 Kearny av., Kearny
Eckert, Wm., 672 Palisade av., Union City
Edgar, Jos. A., 71 Congress st., Jersey City
Edwards, Lena F., 358 Pacific av., Jersey City
Elsasser, Theodore H., 906 Park av., Woodcliff
Enright, James G., 25 Kensington av., Jersey City
Evans, James L., 893 Park av., Woodcliff
Facciolo, Frank, 562 Hudson Blvd., Bayonne
Faison, John B., 45 Glenwood av., Jersey City
Farr, John C., 75 10th st., Hoboken
Fattel, Henry C., 593 36th st., No. Bergen
Federer, John J., 69 Columbia ter., Weehawken
Feinberg, David C., 837 Avenue C, Bayonne
Fellman, Morris, 118 Jewett av., Jersey City
Ferenczi, Louis J., 33 Edwards ct., Bayonne
Fifer, Wm. T., 748 Avenue C, Bayonne
Fineberg, Jacob C., 50 Glenwood av., Jersey City
Finger, Fredk. A., 938 Avenue C, Bayonne
Finke, Chas. H., 317 York st., Jersey City
Finn, Fred A., 921 Bergen av., Jersey City
Finn, H. R. W., 84 Lembeck st., Jersey City
*Flaherty, M. E., Glenwood av., Jersey City
Flitchtenfeld, Morris, 283 4th st., Jersey City
Frank, Morris S., 920 Avenue C, Bayonne
Frank, Nathan, 186 Bowers st., Jersey City
Franklin, Isidor H., 191 Palisade av., Jersey City
Franklin, Louis, 191 Palisade av., Jersey City
Freile, Wm., 25 Tonnele av., Jersey City
Frieman, Hyman, 774 Ave. C, Bayonne
Frundt, Oscar C., 92 Bartholdi av., Jersey City
Gadomski, C. F., 103 Murray st., cor. Ch'ry st., Eliz.
Garibaldi, Louis J., Jr., 1016 Hudson st., Hoboken
Ghee, Euclid P., 115 Claremont av., Jersey City
Ghee, Peter F., 734 Ocean av., Jersey City
Gille, Hugo, 149 Congress st., Jersey City
Ginsberg, Geo., 624 Bloomfield st., Hoboken
Gleeson, Wm. J., 37 Monticello av., Jersey City
Godlin, David R., 610 36th st., No. Bergen
Goldsmith, Alfred, 240 20th st., No. Bergen
Goldstone, Karl H., 16 18th st., West New York
Good, R. B., 949 Park av., Union City
Goodrich, S. L., 812 Ave. C, Bayonne
Granelli, Humbert A., 213 Garden st., Hoboken
Granelli, Michael S., 68 Hudson st., Hoboken
Greenberg, Philip 1902 Hudson Blvd., Jersey City
Greene, Albert D., 195 Palisade av., Union City
Grewal, S. L., 140 E. 52nd st., New York City
Grieco, Emil H., 196 Broadway, Bayonne
Gutmann, Erwin K., 229 Bowers st., Jersey City
Hall, Perry O., 254 Union st., Jersey City
Halligan, Earl J., 254 Montgomery st., Jersey City
Halligan, Harold J., 254 Montgomery st., Jersey City
Halpern, Sophia L., 271 Palisade av., Union City
Hardenberg, Daniel S., 347 Communipaw av. J. City
Harris, Chas. M., 279 Grove st., Jersey City
Harter, Louis F., 174 Bowers st., Jersey City
Hartwell, Henry A., 777 Boulevard E., Weehawken
Harvey, John W., 818 Avenue C, Bayonne
Hasking, Arthur P., 318 Montgomery st., Jer. City
Heilbrunn, Julius, 135 Belmont av., Jersey City
*Heintzelman, B. S., Weehawken
Hekimian, Jacob H., 468 Palisade av., Weehawken
Hernandez, Manuel, 1974 Hudson Blvd., Jersey City
Herradora-Ubeda, Juan R., 2787 Boulevard, Jer. City
Higgins, Gerald L., 94 Lembeck av., Jersey City
Hill, Wm. F., 108 Grand st., Jersey City
Hillel, Jos., 1304 Park av., Hudson Heights
Hoffman, Peter, Jr., 2672 Hudson Blvd., Jersey City
Hollywood, James L., 1818 Hudson Blvd., Jersey City
Hoops, Harold J., 2203 Hudson Blvd., Jersey City
Howeth, John L., 14 Duncan av., Jersey City
Introcaso, Dominick A., 45 Crescent av., Jersey City
Ishkhanian, Nouri I., 656 Palisade av., W. New York
Jacks, Oscar, 476 Mercer st., Jersey City

Jaffe, Benj., 568 Bergen av., Jersey City
Jaffe, Herman M., 2600 Hudson Blvd., Jersey City
Jaffin, Abraham E., 41 Emory st., Jersey City
Jaques, Jennie E., 74 Waverly st., Jersey City
Jensen, Grover H., 169 Lexington av., Jersey City
Jentz, John H., 67 Sherman pl., Jersey City
Jones. John M., Valley rd., R. D., Oakland
Joseph, Benj. M., 2771 Hudson Blvd., Jersey City
Justin, Arthur W., 41 Fulton st., Weehawken
Justin, J. Clement, 1074 Dearborn rd., Palisade
Kaplan, Herman B., 324 44th st., Union City
Keegan, Thos. D., 8 Gifford av., Jersey City
Kelley, Chas. B. P., 921 Bergen av., Jersey City
Kelly, Bernard S., 1954 Hudson Blvd., Jersey City
Kelly, H. R. J., 311-A Brown st., Union City
Kenyon, Thomas A., 14 4th st., Weehawken
Kiely, Eugene M., 926 Hudson st., Hoboken
Kimmel, Meyer L., 142 Manhattan av., Jersey City
Klaus, Henry, 435 Palisade av., Union City
Klugman, Louis W., 696 Avenue C, Bayonne
Kolb, John M., 725 10th st., Union City
Kooperstein, Samuel I., 395 Ogden av., Jersey City
Koppel, Jos. A., 921 Bergen av., Jersey City
Koppel, Leopold A., 921 Bergen av., Jersey City
Kraemer, Samuel H., 309 Baldwin av., Jersey City
Kraut, Arthur M., 2801 Boulevard, Jersey City
Kresch, Philip, 42 W. 22nd st., Bayonne
Kuhlmann, Alvin E., 527 37th st., Union City
Landshof, Chas. A., 50 Glenwood av., Jersey City
Lange, Louis C., 50 Clifton ter., Weehawken
Largay, Arthur O., 937 Avenue C, Bayonne
Larkey, Chas. J., 700 Avenue C, Bayonne
Lawsing, Geo. C., 443 22nd st., West New York
Leining, Albert, 1 4th st., Weehawken
Leir, Jacob K., 9 Garrison av., Jersey City
Lemmerz, Theodore H., 141 Magnolia av., Jer. City
Levine, G. Irving, 2017 Hudson Blvd., Jersey City
Lewis, Livingstone L., 712 Washington st., Hoboken
Linde, Mortimer H., 45 Clendenny av., Jersey City
Lindroth, Lawrence V., 624 Pavonia av., Jersey City
Lipschutz, Chas., 804 Ave. C, Bayonne
Lisanti, Gaetano, 660 Tyler pl., West New York
Little, Alonzo W., Jr., 120 Arlington av., Jer. City
Londrigan, Jos. F., 535 Washington st., Hoboken
Long, Miles T., 2150 Hudson Blvd., Jersey City
Luczynski, Edward W., 28 E. 22nd st., Bayonne
Luippold, Eugene J., 85 Columbia ter., Weehawken
Lupin, Edward E., 727 Avenue C, Bayonne
Lynch, Roland J., Mental Dis. Hosp., Secaucus
Lynn, Irving, 2252 Boulevard, Jersey City
McCarthy, John J., 606 35th st., N. Bergen
McDede, Jos. S., 215 Ege av., Jersey City
McDonald Frank R., 79 Summit av., Jersey City
McLean, Herbert E., 92 Fairview av., Jersey City
McLean, Hugh A., 414 17th st., West New York
McLoughlin, Frank J., 558 Jersey av., Jersey City
*McNenney, Claudio E., 113 Fairview av., Jersey C'y
Madaras, John S., Jr., 870 Avenue C, Bayonne
Madden, Wm. L., 83 Gifford av., Jersey City
Madison, Lewis K., 358 Pacific av., Jersey City
Mangone, Geo. F., 171 Palisade av., Union City
Marono, Michael A., 508 Fourth st., Union City
Maras, Peter E., 80 Tonnele av., Jersey City
Markowitz, Benj. B., 2157 Hudson Blvd., Jersey City
Markowitz, Irwin B., 2157 Hudson Blvd., Jersey City
Marks, David M., 298 4th st., Jersey City
*Marshak, Martin I., 679 Ave. C, Bayonne
Marshall, Frank A., 440 Palisade av., Weehawken
Matera Jos., 506 Garden st., Hoboken
Mathesheimer, Jacob L., 280 Old Bergen rd., J. City
Mathews, Wm. J., 938 Hudson st., Hoboken
Maturi, Vincenzo E., 814 Hudson Blvd., Bayonne
Maver, Wm. W., 532 Bergen av., Jersey City
*Mead, Walter C., 669 Kearny av., Kearny
Meehan, Geo. E., 117 Mercer st., Jersey City
Meltsner, Louis, 904 Hudson st., Hoboken
Meltzer, Louis, 32 W. 33rd st., Bayonne
Mendelsohn, Lewis, 272 Montgomery st., Jer. City
Mersheimer, Christian H., 15 Reservoir av., Jer. City
Meyer, Wm., 436 New York av., Union City
Meyerson, Noah, 428 15th st., West New York
Mickewitch, Stephen A., 650 Ave. C, Bayonne
Miller, Max H., 311 16th st., West New York
Miner, Donald, 921 Bergen av., Jersey City
Morley, Grace C., 2787 Blvd., Jersey City
Morris, David G., 11 W. 26th st., Bayonne
Morrone, John A., 233 Bowers st., Jersey City
Mueller, Geo. H., 102 Summit av., Jersey City
Mulvihill, Wm. J., Jr., 275 Hudson Blvd., Bayonne
Murphy, Edward A., 1 Britton st., Jersey City
Murphy, James M., 2757 Hudson Blvd., Jersey City
Murphy, Leo J., 374 West st., Union City
Murphy, Patrick H. W., 27 Jefferson av., Jersey City
Murray, Jos. A., 765 Avenue C, Bayonne
Mustermann, Otto H., 303 48th st., Union City
Muttart, Geo. W., 702 Ocean av., Jersey City
Mutter, Alfred A., 75 Beech st., Arlington
Nalitt, David I., 28 W. 33rd st., Bayonne
*Nevin, John, Kensington av., Jersey City
Newman, Abraham J., 70 Sherman pl., Jersey City
Nicholson, Frank P., 895 Summit av., Jersey City
*Niemeyer, Frank V., 4610 Blvd., Union City
Norton, James F., 299 Varick st., Jersey City
Nuse, Edward F., 550½ Jersey av., Jersey City
Ockene, Abraham, 494 Palisade av., Union City
O'Connor, John J., 434 New York av., Union City
O'Corman, Michael W., 880 Bergen av., Jersey City
Oestmann, August W., 932 Summit av., Jersey City
O'Hanlon, Geo., Medical Center, Jersey City
Older, Benj., 435 New York av., Union City
Olpp, Archibald E., 316 Bergenline av., Union City
O'Neill, John H., 270 Montgomery st., Jersey City
Opdyke, Levings A., 55 Clinton av., Jersey City
Ortolano, James J., 159 First st., Hoboken
O'Shea, John J., 135 Shippen st., Weehawken
Oshrin, Henry, 750 Park av., West New York
O'Sullivan, John R., 33 Hamilton av., Kearny
Ovens, Ritchie C., 675 Bergen av., Jersey City
Owen, Logan S., 938 Hudson st., Hoboken
Pacicco, Michele, 376 Monmouth st., Jersey City
Pagliughi, John J., 401 18th st., Union City
Pearlstein, Frank, 325 16th st., West New York
Pellarin, John D., 493 New York av., Union City
Penchansky, Sam'l, 847 Ave. C, Bayonne
Pentel, Louis S., 307 16th st., West New York
Perkel, Louis L., 2801 Hudson Blvd., Jersey City
Perlberg, Harry J., 921 Bergen av., Jersey City
Peterson, Chas. A., 921 Washington st., Hoboken
Piltz, Geo. F., 153 25th st., Guttenberg
Pindar, Fredk. S., 960 Park av., No. Bergen
Pinkerton, Wm. A., 854 Avenue C, Bayonne
Piskorski, Abdon V., 604 Jersey av., Jersey City
Plavin, Nathan J., 5460 Hudson Blvd., No. Bergen
Pollak, B. S., Hud. Co. T. B. San., Jersey City
Potter, Benj. P., Hud. Co. T. B. San., Jersey City
Povalski, Alex. W. T., 1925 Hudson Blvd., Jer. City
Purdy, Chas. H., 35 Highland av., Jersey City
Pyle, Louis A., 89 Fairview av., Jersey City
Pyle, Wallace B., 15 Exchange pl., Jersey City
Quigley, Frederic J., 4622 Hudson Blvd., Union City
Quinn, John J., 921 Bergen av., Jersey City
Rector, Jos. M., 681 Bergen av., Jersey City
Reingold, Alex., 221 Garden st., Hoboken
Reitnaur, John S., 518 44th st., Union City
Rieck, Walter R., 379 Kearny av., Kearny
Rieman, Aloysius P., 3566 Hudson Blvd., Jersey City
Riese, Jacob A., 636 Palisade av., West New York
Robbins, Henry B., 144 Mercer st., Jersey City
Roberts, Edgar W., 760 Palisade av., West New Y'k
Rosecrans, James H., 826 Hudson st., Hoboken

Rosenberg, Jacob, 692 Bergen av., Jersey City
Rosenstein, Jacob L., 568 Bergen av., Jersey City
Rowe, Norman L., 828 Grand st., Jersey City
Rundlett, Emilie V., 79 Prospect st., Jersey City
Ruoff, Andrew C., Jr., 494 New York av., Union City
Russell, David L., 690 Bergen av., Jersey City
Ruvane, Jos. J., 38 Bentley av., Jersey City
Sacco, Anthony G., 440 New York av., Union City
Sachs, Wilbert, 921 Bergen av., Jersey City
Salmon, Edw. F., Hud. Co. Contag. Dis.Hosp.,Sec'cus
*Salmon, Edward H., 669 Bergen av., Jersey City
Sandler, Samuel A., 65 Tonnele av., Jersey City
Santangelo, Stephen, 304 Varick st., Jersey City
Saradarian, Albert V., 481 New York av., Union C'y
Schapiro, Jos., 712 Palisade av., Union City
Schenker, Benj. N., 246 5th st., Jersey City
Schept, Samuel S., 523 37th st., Union City
Schlein, August, 707 Park av., Hoboken
Schneckendorf, Sam'l J., 179 Harrison av., Jer. C'y
Schneider, Louis A., 412 17th st., West New York
Schuchner, Wm. F., 550½ Jersey av., Jersey City
Schuck, Traugott J., 58 9th st., Hoboken
Schulman, Abraham S., 4638 Boulevard, Union City
Schwarz, Berthold T. D., 2787 Hudson Blvd., Jer.C'y
Schwarz, Henry J., 5560 Hudson Blvd., No. Bergen
Sciorsci, Edward F., 609 Bloomfield st., Hoboken
Scott, Samuel G., 141 Bergen av., Jersey City
Selinger, Samuel, 413 16th st., West New York
Sexsmith, Geo. H., 719 Ave. C, Bayonne
Shapiro, Maurice, 750 Ave. C, Bayonne
Shapiro, Nathaniel J., 192 Palisade av., Union City
Sheeran, Vincent J., 269 Jewett av., Jersey City
Shepard, Myron, 435 16th st., West New York
Shulman, Nathan L., 538 45th st., Union City
Siegel, Sidney L., 227 N. Second st., Millville
Siegler, Julius, 646 Bergen av., Jersey City
Simeone, Peter A., 555 38th st., Union City
Singer, Sina S., 3443 Blvd., Jersey City
Smith, Alexander L., 2672 Hudson Blvd., Jersey City
Smith, Arthur B. R., 585 Bergen av., Jersey City
Snyder, John E., 1023 Garden st., Hoboken
Snyder, Wm. J., 74 Columbia ter., Weehawken
Spalding, Henry J., 512 45th st., Union City
Spano, Frank, 320 47th st., Union City
Spath, Geo. B., 722 Hudson st., Hoboken
Spence, Henry, 2540 Hudson Blvd., Jersey City
Sprague, Seth B., 301 York st., Jersey City
Stein, Jacob M., 68 Columbia ter., Weehawken
Stockfisch, Robt. H., 3644 Hudson Blvd., Jersey City
Stout, John P., 165 Jewett av., Jersey City
Street, Daniel B., 27 Woodlawn av., Jersey City
Stuart, Wm. C., 518 Hudson st., Hoboken
Sullivan, James A., 46 Bentley av., Jersey City
Sulouff, Samuel H., 662 Newark av., Jersey City
Sussman, Harold, 326 24th st., Union City
Sweeney, Wm. J., 68 Clifton ter., Weehawken
Swiney, Juliana C., 325 Ave. C, Bayonne
Swiney, Merrill A., 325 Ave. C, Bayonne
Taft, Herman L., 25 Liberty pl., Weehawken
Tataryan, Hovsep H., 422 New York av., Union City
Temes, Julius H., 293 Ege av., Jersey City
Thomas, Ralph B., 493 Montgomery st., Jersey City
Tidwell, Harold F., 229 16th st., West New York
Timlin, James W., 64 Beech st., Arlington
Tracy-Dexter, Harriet E., 903 Ave. C, Bayonne
Urevitz, Abraham, 495 New York av., Union City
Valentine, Edwin J. G., 2685 Blvd., Jersey City
Varriano, John L., 3263 Hudson Blvd., Jersey City
Visconti, Jos. A., 711 Garden st., Hoboken
von Deesten, Henry T., 268 Palisade av., Jersey City
Vostrosablin, Nicholas A., 121 Grand st., Jersey City
Vreeland, Hamilton, 232 S. Irving st., Ridgewood
Vreeland, Wm. N., 32 Bergen av., Jersey City
Wallack, Eli A., 333 Fairmount av., Jersey City
Walscheid, Arthur J., 440 38th st., Union City
*Ward, John V., 438 Palisade av., Union City
Waters, Edward G., 39 Gifford av., Jersey City
Watman, Anthony J., 2761 Hudson Blvd., Jer. City
Weber, Walter D., 305 23rd st., Union City
Weiss, Abram, 456 Palisade av., Weehawken
Weiss, Morris J., 734 Ave. C, Bayonne
Welcher, Howard A., 5436 Hudson Blvd., No. Bergen
Wheeler, James A. V., 85 Van Reypen st., Jer. City
White, Hugh M., 901 Summit av., Jersey City
White, Thos. J., 50 Glenwood av., Jersey City
Wilcox, Frank A., 329 16th st., West New York
Williamson, Wm. L., 22 W. 22nd st., Bayonne
Willis, John, Jr., 268 Palisade av., Jersey City
Wiren, Wm. E., 189 Ave. C, Bayonne
Woelfle, Henry E., 907 Summit av., Jersey City
Woodruff, Stanley R., 16 Enos pl., Jersey City
Yeaton, Wm. L., Jr., 204 11th st., Hoboken
Yudkoff, Wm., 403 Hudson Blvd., Bayonne
Zenneck, Junius F., 17 4th st., Weehawken
Zitani, Alfred M., 937 Washington st., Hoboken

Associate Members

Bergmeyer, Josef T., 422 20th st., West New York
Buckley, Richard F., 1106 Bloomfield st., Hoboken
Cohen, Samuel, Medical Center, Jersey City
Danielson, John J., 977 Bergen Trnpk., No. Bergen
Felitti, Vincent J., 6 31st st., No. Bergen
Flicker, David J., 342 Kearny av., Kearny
Harz, Wm. V., 817 Ave. C, Bayonne
Higgins, John T., 145 Highland av., Jersey City
Lynch, James F., 244 Stegman st., Jersey City
Mackin, John J., 596 Bergen av., Jersey City
McCarron, James A., 341 Ave. A, Bayonne
McCarthy, Cornelius P., 327 Blvd., Bayonne
Matturri, Dominick A., 174 Clinton av., Jersey City
Padney, Edward V., 139 Montgomery st., Jersey C'y
Velluzzi, Joseph F., 311 Ave. C, Bayonne

Honorary Members

Cropper, Chas. W., Clarkt'n CountryCl'b,Nyack,N.Y.
Vreeland, Hamilton, 232 S. Irving st., Ridgewood

Transferred

Margulies, Chas., to Essex County Medical Society
Siegel, Sidney L., to Cumberland Co. Medical Society
O'Connor, Bernard A., to Essex Co. Medical Society

Number of active members and basis of representation, 388, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937

HUNTERDON COUNTY (10)

Society organized June 12, 1821. Meets on the fourth Tuesday of January, April, July and October, April being the Annual Meeting.

President, Lane, E. W., Bloomsbury

First Vice-President, Harner, R. M., High Bridge

Second Vice-Pres., Fuhrmann, Barclay S., Fl'm'gt'n

Secretary, Gramsch, A. Louis, Glen Gardner

Treasurer, Closson, Edward W., Lambertville

Reporter, Gramsch, A. Louis, Glen Gardner

Active Members

Apgar, Francis A., 68 Main st., Oldwick
Baker, Philip W., High Bridge
Boothby, I. Roland, Clinton
Boyer, Chas. G., Annandale
Christensen, Alex H., Lebanon
Clark, Frank G., White House Station
Closson, Edward W., Lambertville
Coleman, Austin H., Clinton
Fuhrmann, Barclay S., 10 Main st., Flemington
Fulper, Theodore B., Hampton
Garfinkel, Abraham, 30 Broad st., Flemington
Gramsch, A. Louis, Glen Gardner
Harman, Byron M., Essex Mountain San., Verona
Harman, Harry M., 25 Bridge st., Frenchtown
Heil, Alva A., Milford
Henry, Geo., Flemington
Knox, Howard A., New Hampton
Lane, Edgar W., Bloomsbury
McCorkle, Wm. E., Ringoes
Thomas, Floyd A., Flemington
Tompkins, Grenelle B., Flemington

Honorary Members

Ely, Lancelot, Somerville
Haussling, Francis R., Newark
Marsh, Elias J., Paterson
Morrison, J. B., Newark
Newcomb, Marcus W., Browns Mills
Quigley, Frederic J., Union City
Scammell, Frank C., Trenton
Sommer, Geo. N. J., Trenton
Snedecor, Spencer T., Hackensack

Number of active members and basis of representation, 21, Feb. 5, 1937.

MERCER COUNTY (11)

Society organized May 23, 1848. Meets on the second Wednesday of each month except July, August and September, at 8:30 P. M., in the Trenton Country Club. Annual Meeting in December. Annual Banquet second Wednesday in November.

President, D'Arcy, Walter E., Trenton

Vice-President, Little, Wm. R., Trenton

Secretary, Hutchinson, A. D., Trenton

Treasurer, North, Harry R., Trenton

Reporter, Hutchinson, A. D., Trenton

Active Members

Abey, Wm. J. H., 23 N. Delaware av., Pennington
Ackley, David B., 21 N. Clinton av., Trenton
*Adams, Chas. F., 34 W. State st., Trenton
Anthony, David W., 201 Witherspoon st., Princeton
Applegate, Edward T. R., 1125 Greenw'd av.,Tr'nt'n
Applestein, Robt., 569 E. State st., Trenton
Aronis, Harry R., 239 E. Hanover st., Trenton
Ashley, Harmon H., 190 W. State st., Trenton
Barrows, Arthur M., 440 Hamilton av., Trenton
Barry, Rolla G., 908 W. State st., Trenton
Bayne, J. K., 12 Princeton av., Princeton
Beairsto, Everett B., 178 W. State st., Trenton
Belfer, Jacob J., 1235 Chambers st., Trenton
Belford, Ralph J., 90 Nassau st., Princeton
Bellis, Horace D., 437 E. State st., Trenton
Belting, Arthur W., 202 E. Hanover st., Trenton
Berger, Harry, 921 S. Clinton av. Trenton
Berman, Jacob J., 409 Market st., Trenton
Blackwell, Enoch, 28 W. State st., Trenton
Blaugrund, Samuel, 190 W. State st., Trenton
Blum, Jos. M., 128 Mill st., Trenton
Buckley, Richard T., Jr., Peddie School, Hightstown
Burroughs, Edmund W., 701 W. State st., Trenton
Byer, M. Yale, 827 E. State st., Trenton
Carabelli, A. Albert, 306 Hamilton av., Trenton
Carroll, C. Walter, 117 Centre st., Trenton
Carroll, Wm. V., 211 Academy st., Trenton
Cella, Chas. F., 335 Hamilton av., Trenton
Chesner, Wm A.., 1111 Hamilton av., Trenton
Chianese, C. Chester, 464 Hamilton av., Trenton
Cohen, Chas. C., 217 W. Hanover st., Trenton
Cohen, Herman, 1301 Hamilton av., Trenton
Cohen, Wm., 1007 Greenwood av., Trenton
Collier, Wm. S., 1000 S. Broad st., Trenton
Collins, Henry J., 1160 Hamilton av., Trenton
Comfort, John B., 50 S. Clinton av., Trenton
Connelly, John A., 212 W. State st., Trenton
Corio, Geo. A., 307 S. Clinton av., Trenton
Corrigan, Patrick H., 1720 S. Broad st., Trenton
Cottone, Rosario J., 683 Princeton av., Trenton
Cowlbeck, Harry D., 224 W. State st., Trenton
Cox, Harold C., 208 Stockton st., Hightstown
D'Arcy, Walter E., 545 E. State st., Trenton
Davenport, Irwin P., 194 W. State st., Trenton
Davis, Harold L., 178 W. State st., Trenton
Davison, Royden W., 205 W. State st., Trenton
Denelsbeck, J. Otis, 878 E. State st., Trenton
Dimun, John T., 960 S. Broad st., Trenton
Doranz, Harold K., 491 Centre st., Trenton
Drezner, Henry L., 507 S. Warren st., Trenton
Elias, Elmer J., 827 S. Broad st., Trenton
Ellis, Van Mashburn, Princeton
Engelhart, Ferdinand K., 701 Stuyvesant av.,Trent'n
Epstein, Rubie, 606 Perry st., Trenton
Ernest, Richard B., Jr., 240 W. State st., Trenton
Fabian, Paul L., 520 Princeton av., Trenton
Farmer, Walter D., Church st., Allentown
Fee, Elam K., Main st., Lawrenceville
Fell, Alton S., 529 E. State st., Trenton
Fessler, Albert J., 1544 S. Broad st., Trenton
Fine, Sydney G., New Jersey State Hospital, Trent'n
Finegan, Paul J., 200 W. State st., Trenton
Fiorello, Jos. R., 706 Princeton av., Trenton
Forer, Robt., 247 Centre st., Trenton
Franzoni, Andrew E., 938 Brunswick av., Trenton
Friedman, Meyer H., 526 N. Clinton av., Trenton
Friedmann, Leonard L., 484 Princeton av., Trenton
Fuchs, Jacob N., 1267 S. Broad st., Trenton
*Funkhowser, E. B., State Hospital, Trenton

Goldberg, Ben. M., 1156 E. State st., Trenton
Gordon, Clark H., 808 E. State st., Trenton
Graham, Ernest E., 4273 S. Broad st., Yardville
Guglielmelli, Angelo D., 449 Hamilton av., Trenton
Guidotti, F. P., 432 Hamilton av., Trenton
Haggerty, D. Leo, 227 N. Warren st., Trenton
Haines, Evelyn M., 432 Hamilton av., Trenton
Hale, Henry E., Jr., Battlefield Farm, Princeton
Hammell, Frank M., 137 S. Main st., Allentown
Haney, John J., 167 Cooper st., Trenton
Harman, James R., 1819 S. Broad st., Trenton
Harman, Wm. J., 740 W. State st., Trenton
Hawke, Edward K., New Jersey State Hosp., Trent'n
Hess, George A., River rd., Titusville
Hiden, Jos. C., 199 Nassau st., Princeton
Hirschfield, Bernard A., 1404 Greenw'd av., Trent'n
Holland, John A., 54 Prospect st., Trenton
Hunter, Floyd D., 3620 Nott'gh'm wy., Hamilt'n Sq.
Hutchinson, A. Dunbar, 913 W. State st., Trenton
Hutchinson, Geo. F., 55 Mercer st., Hamilton Sq.
Iams, Sam'l H., Liberty pl. & Wescott rd., Prinect'n
Ireland, Allen G., 28 W. State st., Trenton
Ivins, Wm. C., 214 E. Hanover st., Trenton
Jaspan, Samuel C., 820 Division st., Trenton
Kachdorian, Vartan, 930 Brunswick av., Trenton
Klempner, Paul, 414 Market st., Trenton
Kondor, Jos. S., 978 S. Broad st., Trenton
Koplin, Nathaniel H., 142 W. State st., Trenton
Kustrup, John F., 1418 S. Broad st., Trenton
Lapin, Samuel B., 542 W. State st., Trenton
Lavine, Barney D., 630 N. Clinton av., Trenton
Lettiere, Anthony J., 425 E. State st., Trenton
Levin, Louis, 140 W. State st., Trenton
Levy, Irvin, 329 Gardner av., Trenton
Little, Wm. R., 493 W. State st., Trenton
MacDermid, Lynden E., 506 F'rnsw'rth av.,B'rd'nt'n
MacFarland, Burr W., 419 W. State st., Trenton
Majeski, Henry J., 1015 Brunswick av., Trenton
*Marotte, Chas. L., S. Clinton av., Trenton
Martin, Elizabeth L., 10 Bayard lane, Princeton
Matthews, Clifford B., 1158 E. State st., Trenton
McCandliss, Wm. K., N. J. State Hosp., Trenton
McCullough, John H., 523 E. State st., Trenton
McGuigan, Francis A., 212 N. Warren st., Trenton
McGuire, James J., 122 W. State st., Trenton
Means, Paul B., N. J. State Hospital, Trenton
Miller, Earle K., 2502 Nottingham way, Mercerv'le
Miller, Gerald H., N. Main st., Cranbury
Miller, Samuel R., 31 N. Main st., Pennington
Mitchell, Chas. H., 1100 W. State st., Trenton
Mitskas, Theodore V. J., Main st., Crosswicks
Moriconi, Albert E., 438 Hamilton av., Trenton
Mras, John M., 977 S. Broad st. Trenton
Munro, Jeannette, 293 Nassau st., Princeton
Murphy, James A., 467 Hamilton av., Trenton
Murto, Thomas V., 532 W. State st., Trenton
Nonziato, Frank A., 50 Centre st., Trenton
North, Harry R., 160 W. State st., Trenton
O'Rourke, James J., 871 Stuyvesant av., Trenton
Pantaleone, Jos., 504 Hamilton av., Trenton
Parker, Horace N., 72 N. Clinton av., Trenton
Pessel, Johannes F., 224 W. State st., Trenton
Peterson, Walter R., 312 W. State st,. Trenton
Phillips, Robt. H., 144 W. State st., Trenton
Pierson, Carl L., 178 W. State st., Trenton
Pierson, Jos. R., 64 W. Broad st., Hopewell
Potter, Ellen C., 301 W. State st., Trenton
Powis, Ethel M., 198 W. State st., Trenton
Poyas, Morton L., 1871 Pennington rd., Trenton
Proctor, Francis E., 1245 Greenwood av., Trenton
Purcell, Ernest F., 800 Stuyvesant av., Trenton
Ragany, Jos., 966 S. Broad st., Trenton
Rainey, Willard G., 34 Bayard lane, Princeton
Rapp, Robert F., 302 Main st., Hightstown
Reisinger, Paul B., 369 W. State st., Trenton
Rogers, Alvin S., 233 N. Warren st., Trenton
Rogers, Laurence H., Tr'nt'n Munic. Hosp., Tr'nt'n
Rowan, Henry M., 224 W. State st., Trenton
Salway, Benj., 321 S. Broad st., Trenton
Scammell, Frank G., 40 S. Clinton st., Trenton
Scasserra, Benedict B., 163 Nassau st., Princeton
Schildkraut, Jacob M., 170 W. State st., Trenton
Schroeder, Henry J. L., 110 W. State st., Trenton
Seely, Roy B., 78 N. Clinton av., Trenton
Seidelman, S. E., 1919 Greenwood av., Trenton
Seitzick-Robbins, Hannah E., 733H'milt'n av.,Tr'nt'n
Sekerak, Albert J., 984 S. Broad st., Trenton
*Shaw, J. B., 119 S. Warren st., Trenton
Sica, L. Samuel, 431 E. State st., Trenton
Sill, John B., 1129 Hamilton av., Trenton
Silver, E. Drew, 136 Stockton st., Hightstown
Silver, Geo. A., 242 Stockton st., Hightstown
Sinton, John Y., Imlaystown
*Sista, Chas. R., 476 Hamilton av., Trenton
Slack, Clarence J., 230 W. State st., Trenton
Smith, Houghton C., 1063 S. Clinton av., Trenton
Smith, Wm. H., 34 W. State st., Trenton
Sommer, Geo. N. J., 120 W. State st., Trenton
Sommer, Geo. N. J., Jr., 120 W. State st., Trenton
Spradley, Jeems B., N. J. State Hospital, Trenton
Stein, Louis A., 226 W. State st., Trenton
Stone, Robert G., N. J. State Hospital, Trenton
Storaci, Frank S., 703 Hamilton av., Trenton
Summers, Alfred D., 180 Nassau st., Princeton
Sutnick, T. B., 801 S. Broad st., Trenton
Swern, Nathan, 130 W. State st., Trenton
Swertfeger, Herbert W., 106 W. Broad st., Hopewell
Taylor, Walter A., 450 Rutherford av., Trenton
*Tempesto, J. A., 306 Hamilton av., Trenton
Treiber, Benj. A., 626 Perry st., Trenton
Turner, Irvine F. P., 224 W. State st., Trenton
Urbaniak, Henry S., 883 Brunswick av., Trenton
Vaczi, Stephen, 983 S. Broad st., Trenton
Vanneman, Jos. S., 45 Princeton av., Princeton
Waldron, Edward L., 126 W. State st., Trenton
Walsh, Thos. J., 514 Greenwood av., Trenton
Warter, Peter J., 626 W. State st., Trenton
Waters, Chas. H., 126 W. State st., Trenton
Watov, Samuel E., 603 Beatty st., Trenton
Watson, Fredk. S., 238 W. State st., Trenton
Watts, Wilbur, 436 E. State st., Trenton
Wayman, Bernard R., 834 Stuyvesant av., Trenton
West, Edgar L,. 443 E. State st., Trenton
Wiesler, Howard M., 128 Third st., Trenton
Wikoff, John L., 799 Pennington av., Trenton
Wilbur, Wm. L., 156 Stockton st., Hightstown
Wilkes, LeRoy A., 143 E. State st., Trenton
Williams, Geo. W., 217 N. Warren st., Trenton
Williams, Harry D., 527 E. State st., Trenton
Wilner, Arthur A., 205 Market st., Trenton
Wittenborn, Wm. F. J., 1613 Brunswick av., Tr'nt'n
Wright, Howard E., 173 Nassau st., Princeton
Yaeger, Leslie A., 470 Hamilton av., Trenton
Yazujian, Dikran M., 562 E. State st., Trenton
Zandt, Fredk. B., 16 Mercer st., Hamilton Square
Zentner, Maurice R., 1271 Hamilton av., Trenton
Zimskind, Joshua N., 210 W. State st., Trenton

Associate Members

Allman, Sydney J., 215 N. Main st., Hightstown
Atkinson, James, 423 E. State st., Trenton
Borrella, D. D., 476 Hamilton av., Trenton
Burbidge, J. Raymond, McCosh Infirmary, Princet'n
Clark, Alice L., 206 W. State st., Trenton
Clark, Chas E., N. J. State Hospital, Trenton
Davis, John E., Jr., N. J. State Hospital, Trenton
Deitz, Joseph R., 320 Centre st., Trenton
Dembinski, T. Henry, 1238 S. Clinton av., Trenton
Eames, W. N., 1871 Pennington rd., Trenton
Finkle, Lester J., 225 Perry st., Trenton

Fluck, D. A., 548 W. State st., Trenton
Friedman, Max, 822 Chambers st., Trenton
Horhovitz, Geo. I., 324 S. Broad st., Trenton
Kohn, Joseph J., 207 Calhoun st., Trenton
Lapin, Louis P., 15 Crosswicks st., Bordentown
Lavine, Sidney B., 134 W. State st., Trenton
Magee, Harold S., N. J. State Hospital, Trenton
Miller, Chas. W., Jr., N. J. State Hospital, Trenton
Rampona, Jos. M., 118 Nassau st., Princeton
Rita, James J., 235 S. Clinton av., Trenton
Tomec, Otto C., 407 W. State st., Trenton
Yates, Munford R., 119 Nassau st., Princeton

Honorary Members

Pierson, Theodore A., 10 E. Broad st., Hopewell
Rogers, Wm. N., 1255 Brunswick av., Trenton

Resigned

D'Gianni, M H.

Transferred

Miller, C. W., Jr., from Camden Co. Medical Society
Metzger, Karl F., to Monmouth Co. Medical Society

Number of active members and basis of representation, 201, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937

MIDDLESEX COUNTY (12)

Society organized June 11, 1816. Meets on the third Wednesday of each month, September to June inclusive. Annual Meeting in December.

President, Rowland, John H., New Brunswick

Vice-President, Smith, J. V., Perth Amboy

Secretary, Sandella, J. F., New Brunswick

Treasurer, Smith, A. L. M., New Brunswick

Reporter, Calvin, Charles, Perth Amboy

Active Members

Anderson, John F., 195 College av., New Brunswick
Avery, Philip S., Middlesex Gen. Hosp., New Bruns.
Bassett, Lavern C., 320 New Market rd., Dunellen
*Beekman, Jesse H., Sayreville
Belafsky, Henry A., 472 Rahway av., Woodbridge
Berkow, Samuel G., 138 Market st., Perth Amboy
Breslow, Samuel, 157 Market st., Perth Amboy
Brody, Morton S., 75 Livingston av., New Brunsw'k
Brown, Fredk. L., 67 Livingston av., New Brunsw'k
Burnett, Chas. B., 109 Main st., So. River
Calvin, Chas. H., 80 Commerce st., Perth Amboy
Clarke, Francis M., 116 New st., New Brunswick
Cohen, Nathan B., 232 State st., Perth Amboy
Collins, James J., 116 Main st., Woodbridge
Cooper, Irving J., 116 Livingston av., New Bruns.
Copleman, H. B., 50 Livingston av., New Brunsw'k
Cottrell, Judson G., 159 Market st., Perth Amboy
Cronk, Edwin I., 57 Livingston av., New Brunsw'k
Degenhardt, Ira H., 51 Livingston av., New Bruns.
Dieker, Howard E., 78 Main st., South River
Downs, Louis S., 153 Pershing av., Carteret
Fagan, James L., 51 Bayard st., New Brunswick
Faulkingham, Ralph J., 61 Livingston av., New Br.
Feher, Ladislas A. M., 177 Somerset st., New Bruns.
Fine, Hyman P., 151 Market st., Perth Amboy
Fishkoff, Alexander H., 132 Market st., Perth Amb'y
Fithian, Geo. W., 266 High st., Perth Amboy
Forney, Norman N., 44 N. Main st., Milltown
Gauzza, Valentine P., 505 New Brunswick av., Fords
Glasser, Benj. F., 316 George st., New Brunswick
Grieve, James, 88 Market st., Perth Amboy
Gutowski, Jos. M., 433 Brace av., Perth Amboy
Haight, Harry W., 118 Raritan av., New Brunswick
Hauber, Eugene A., 6 Quaid st., Sayreville
Haywood, Henry, Jr., 49 Paterson st., New Brunsw'k
Henry, Frank C., Jr., 214 Smith st., Perth Amboy
Hilker, Geo. F., 258 Maple st. Perth Amboy
Hinton, Samuel H., Washington rd., Parlin
Hoffman, F. M., 91 Bayard st., New Brunswick
Howley, Bartholomew M., 419 George st., NewBruns.
Hunt, Melvin M., 16 Jackson st., South River
Jablonski, J. J., 100 Main st., Sayreville
Jacobson, Murray B., 241 State st., Perth Amboy
Kinney, Selden T., 250 Main st., South Amboy
Kleiber, Estelle E., 139 New st., New Brunswick
Klein, Edward F., 136 Market st., Perth Amboy
Klein, Wm., 85 Bayard st., New Brunswick
Kler, Joseph H., 77 Livingston av., New Brunswick
Koelsch, Frederic J. E., 14 Kirkp'tr'k st., New Brun.
Kovarsky, Albert E., 255 State st., Perth Amboy
Kraczyk, M. J., 207 Whitehead av., South River
Kramer, Samuel E., 121 Market st., Perth Amboy
Leonard, Geo. F., 65 N. 5th av., New Brunswick
Lesh, Vincent O., 114 S. Stevens av., South Amboy
Lief, Lawrence H., 41 Railroad av., Jamesburg
London, Wm., 255 State st., Perth Amboy
Long, Pauline A., 22 Livingston av., New Brunsw'k
Lund, John L., 267 High st., Perth Amboy
McCormick, Wm. H., Jr., 266 Market st., Perth Amb.
McGovern, John F., Jr., 24 Livingston av., N. Bruns
McKiernan, Robt. L., 97 Bayard st., New Brunsw'k
McKinstry, J. W., Railroad av., Jamesburg
MacDowall, John L., 113 Market st., Perth Amboy
Mann, Jacob J., 255 State st., Perth Amboy
Mark, Jos. Sidney, 102 Green st., Woodbridge
Marvin, Dorothy H., 51 Livingston av., New Bruns.
Massey, John B., 140 Baldwin st., New Brunswick
Meinzer, Martin S., 147 Market st., Perth Amboy
Merrill, Chas. F., 16 S. Third av., Highland Park
Molitch, Matthew, N. J. St. Home Boys, Jamesb'g
Morris, Carlyle, Spring st. & Lake av., Metuchen
Nafey, Herbert W., 51 Livingston av., New Bruns.
Naulty, Chas. W., Jr., 403 High st., Perth Amboy
Panigrosso, Louis R., 284 Washington st., P. Amboy
Paschal, Geo. W., Jr. 96 N. Main st., Milltown
Pellicane, Anthony J., 191 Sandford st., New Bruns.
Pinerman, Robt. B., 269 Bordentown av., So. Amboy
Platt, Thos. H., 307 N. Washington st., Dunellen
Rineberg, Irving E., 94 Bayard st., New Brunswick
Rona, Maurice, 159 Bayard st., New Brunswick
Rothschild, Karl, 149 Livingston av., New Brunsw'k
Rowland, John H., 159 New st., New Brunswick
Runyon, Laurance P., 80 Somerset st., New Bruns.
Sandella, Jos. F., 169 New st., New Brunswick
Scott, Fredk. W., 103 Bayard st., New Brunswick
Sender, Fannie, 123 Main st., South River
Sherman, Wm. E., 88 Schureman st., New Brunsw'k
Shull, John V., 84 Market st., Perth Amboy
Silk, Chas. I., 278 High st., Perth Amboy
Sirott, Barnett H., 413 State st., Perth Amboy
Slobodien, Benj. F., 107 Market st., Perth Amboy
Smith, Arthur L. M., 62 Bayard st., New Brunsw'k
Smith, John V., 463 State st., Perth Amboy
Spencer, Ira T., 152 Main st., Woodbridge
Spritzer, Theo. D., 21 Schuyler av., New Brunsw'k
Steffens, Chas. T., 307 N. Washington av., Dunellen
Stein, Wm., 73 Livingston av., New Brunswick
Strandberg, Herbert, 94 Washington av., Carteret

Sullivan, Chas. J., 57 Paterson st., New Brunswick
Szuch, Nicholas, 159 Main st., South River
Taber, Fredk. S., 49 Paterson st., New Brunswick
Toy, Calvert R., 22 Kirkpatrick st., New Brunswick
*Traverso, Daniel, Belmar
Tyrrell, Geo. W., 380 State st., Perth Amboy
Uhr, Jacques S., 131 Livingston av., New Brunsw'k
Urbanski, Adrian X., 148 Market st., Perth Amboy
Urbanski, Matthew F., 314 Washington st., P. Amb'y
Van Dyke, Benj. S., Cranbury
Walker, Robt. B., 108 Church st., New Brunswick
Watson, Price T., 137 N. Main st., Milltown
Weber, John F., 264 Main st., South Amboy
Wetterberg, Louis F., 389 School st., Woodbridge
White, Henry J., Roosevelt Hosp., Metuchen
Wilentz, Wm. C., 188 Market st., Perth Amboy
Witmer, John D., 456 Middlesex av., Metuchen

Associate Members

Gessner, Gerard R., 28 S. Third av., Highland Park
Gurshan, Sol, 280 Amboy av., Metuchen
Hunter, Cyril I., Perth Amboy Gen. Hosp., P. Amb'y
Mann, Benjamin, 468 Brace st., P. Amboy
Margaretten, Edward I., 262 High st., Perth Amboy
Shayevitz, A., 170 Main st., South River
Smith, L., Dayton
Spritzer, Theo. D., High Point Park
Walters, Geo. M., 179 Main st., Woodbridge

Honorary Members

Applegate, Grover T., 71 Livingston av., N. Bruns.
Hunt, Alonzo C., 625 Middlesex av., Metuchen

Resigned

Longbothum, Geo. T.

Transferred

Massey, John B., from Somerset Co. Medical Soc.
Panigrosso, Louis R., from Somerset Co. Med. Soc.
White, H. J., from Union County Medical Society
Davidson, M., to Union County Medical Society
Horoschak, Anna., to Union County Medical Society

Number of active members and basis of representation, 113, Feb. 5, 1937.

MONMOUTH COUNTY (13)

Society organized July 24, 1816. Meets on the fourth Wednesday of each month from October to June inclusive. Annual Meeting on the fourth Wednesday in April.

President, Rullman, Walter A., Red Bank
Vice-President, Parry, O. K., Asbury Park
Secretary-Treasurer, Featherston, Dan'l F., Asb. P'k
Reporter, Holters, O. R., Asbury Park

Active Members

*Ackerman, James, Asbury Park
Albright, Louis F., 118 Madison av., Spring Lake
Altschul, Frank J., 177 Garfield av., Long Branch
Baeseman, R. Winfield, 501 Grand av., Asbury Park
Bailey, Charles P., 422 First st., Lakewood
Baker, Elsworth F., State Hospital, Marlboro
Becker, Sidney D., 140 Maple pl., Keyport
Beveridge, Wm. W., 1000 Grand av., Asbury Park
Binder, Jos., 149 Garfield av., Long Branch
Blaisdell, C. Byron, 489 Broadway, Long Branch
Bornstein, Paul K., 415 So. Lake dr., Belmar
Bossone, Joseph E., 172 Garfield av., Long Branch
Boyd, John B., 67 E. Front st., Red Bank
Brown, Harvey S., 5 Club pl., Freehold
Brown, Kenneth G., 603 Asbury av., Asbury Park
Bullwinkel, Fredk., Oc'n Blvd. & 4th av., Atl.Highl'ds
Campbell, Wm. K., 96 Third av., Long Branch
Carey, David S., 11 E. Main st., Freehold
Carter, Jos. F. S., 142 Atkins av., Asbury Park
Cassidy, Samuel H., 50 Osborn st., Keyport
Clark, John C., 404 Asbury av., Asbury Park
Clayton, John C., 73 W. Main st., Freehold
Colby, Maxwell X., 287 Westwood av., Long Branch
dePons, Isabel S. C., 501 Grand av., Asbury Park
Dewis, Edwin G., 21 Westra st., Interlaken
Diamond, David I., Oceanport av., Oceanport
Edelson, Samuel, 1141 Corlies av., Neptune
Fairbanks, Warren H., 27 Broadway, Freehold
Featherston, Daniel F., Jr., 506 Fourth av., Asb. P'k
Feinberg, Harry D., 384 Second av., Long Branch
Feman, J. G., 141 Main st. Keansburg
Fisher, James A., 501 Grand av., Asbury Park
Freedman, Harold H., 63 W. Main st., Freehold
Gesswein, Carl A., 35 Church st., Matawan
Glazer, Edward, 501 Grand av., Asbury Park
Goff, Frank J., 62 Maple av., Red Bank
Gordon, J. Berkley, N. J. State Hosp., Marlboro
Graves, Chas. C., Jr., N. J. State Hosp., Marlboro
Guertin, Diomede, N. J. State Hosp., Marlboro
Guillium, Wm. H., 505 Fourth av., Asbury Park
Haines, Emerson S., 901 Grand av., Asbury Park
Hancock, Michael Q., 705 D st., Belmar
Hardy, John W., 53 Main st., Farmingdale
Hausman, Samuel W., 50 W. Front st., Red Bank
Heatley, Wm., 335 Broad st., Red Bank
Herrman, Wm. G., 501 Grand av., Asbury Park
Hill, John A., 511 Cedar av., Allenhurst
Holman, Francis W., 123 Broad st., Keyport
Holters, Otto R., 1002 Emory st., Asbury Park
Hyer, Oscar H., 210 Main st., Matawan
Ingling, Harry W., 51 W. Main st., Freehold
Jamison, Wm. F., 501 Grand av., Asbury Park
Jones, Granville L., N. J. State Hosp., Marlboro
Jordan, Jos. C., 238 E. Main st., Manasquan
Kanses, Edmund S., 51 W. River rd., Rumson
Kazmann, Harold A., 406 Broadway, Long Branch
Knapp, Victor, 505 Second av., Asbury Park
Krohn, Marc, Campbell av., Belford
Leighton, Robt. L., 401 Ludlow av., Spring Lake
Leonard, Lothair, L., 615 Asbury av., Asbury Park
Lorezno, Michael J., 75 Riverside av., Red Bank
MacKenzie, Robt. A., 501 Grand av., Asbury Park
Magee, David M. P., 407 Sewall av., Asbury Park
Maher, John E., 90 Third av., Long Branch
Makin, John B., 501 Grand av., Asbury Park
Manahan, Daniel V., 55 E. Front st., Red Bank
Mason, Howard B., 90 W. Main st., Freehold
Matthews, Wm., 139 Broad st., Red Bank
McDonnell, Geo. J., 80 W. Main st., Freehold
McKelvie, Julius C., 55 Rockwell av., Long Branch
McTague, Robt. S., 9 Memorial Pkwy., Atl. Highl'ds
Metzger, Karl F., 603 Ninth av., Belmar
Miele, Frank A., 314 Carr av., Keansburg
Miller, Samuel T., 1408 Grand av., Asbury Park
Moffatt, Barclay W., Nut Swamp rd., Red Bank
Murphy, Chas. M., 21 Main st., Farmingdale
Neiderhoffer, Sydney L., 469 Broadw'y, Long Br'nch
Nichols, Stanley, 501 Grand av., Asbury Park
Niemtzow, Frank, 45 E. Main st., Freehold
O'Mara, John A., 314 St. Clair av., Spring Lake
Osborn, Adam D., 519 Sixth st., Belmar
Parker, James W., 175 Shrewsbury av., Red Bank

Parry, Oliver K., 601 Bangs av., Asbury Park
Perrine, Cornelius C., 500 River rd., Red Bank
Perrotta, Anthony J., 94 Maple av., Red Bank
Pieper, Howard C., 426 Bath av., W. Long Branch
Podell, Alexander A., 51 E. Front st., Red Bank
Pons, Carlos A., 501 Grand av., Asbury Park
Pregnall, James P., 501 Grand av., Asbury Park
Quirk, Martin A., 90 W. Front st., Red Bank
Reynolds, Geo. G., 64 W. Main st., Freehold
Robinson, Ernest A., 149 Atkins av., Asbury Park
Robinson, Wm. A., 62 Main av., Ocean Grove
Rowland, James J., 321 Bay av., Highlands
Rullman, Walter A., 58 W. Front st. ,Red Bank
Sacco, Gregory E., 191 Broad st., Red Bank
Sands, Ordis L., 501 Grand av., Asbury Park
Sayre, Wm. D., 69 Maple av., Red Bank
Schlossbach, Theodore, 94 S. Main st., Ocean Grove
Schmidt, Albert F., 81 Union av., Manasquan
Scott, Elmer A., Belle Mead Sanatorium, Belle Mead
Sewell, Stephen, 212 Jersey av., Spring Lake
Shanik, Wm., 415 Sunset av., Asbury Park
Silverstein, Max. 605 First av., Asbury Park
Slocum, Harry B., Bath & Westw'd avs., L'g Branch
Steinbock, Fredk. W., E. C. Hazard Hosp., L'g Br.
Stevenson, Geo. S., W. Front st., Red Bank
Strahan, Frank G., 473 Broadway, Long Branch
Straughn, Clinton C., 23 Monmouth st., Red Bank
Strauss, Arthur, 130 Pavilion av., Long Branch
*Traverso, Daniel, 705 D st., Belmar
Trippe, Clarence M., 702 Asbury av., Asbury Park
Upham, Helen F., 305 Third av., Asbury Park
Vaccaro, S. P., 511 Third av., Asbury Park
Villapiano, Jos. G., 701 Sunset av., Asbury Park
Wallin, Alfred C., 166 Main st., Matawan
Watkins, Robt. E., 517 Fifth av., Belmar
Wiener, Jos., 601 Bangs av., Asbury Park
Wilbur, Franklin L., 711 Grand av., Asbury Park
Wilkins, Stanley O., 41 E. Front st., Red Bank
Wilson, Robt. B., 91 Broad st., Red Bank
Wise, Lester D., 119 Morris av., Long Branch
Woodruff, Ralph G., Main st., Englishtown
Woronoff, Murray, 120 Main st., Keyport

Honorary Members

Pietri, Raul, 501 Grand av., Asbury Park
Ransohoff, N., Brighton av., Long Branch

Resigned

Hunt, Geo. H., Red Bank
Toren, Julius, Marlboro

Transferred

Metzger, Karl F., from Mercer Co. Medical Society

Number of active members and basis of representation, 122, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937.

MORRIS COUNTY (14)

Society organized June 11, 1816. Meets on the third Thursday in each month from October to June, inclusive. Annual Meeting in June.

President, Sherman, Byron G., Morristown

Vice-President, Williams, Louis E., Madison

Secretary, Young, George, Morristown

Treasurer, Harrington, J. Henry, Rockaway

Reporter, Curry, Marcus A., Greystone Park

Historian, Mial, L. L., Morristown

Active Members

Abell, Elvira D., Morristown
Ackermann, Edward, 5 Richards av., Dover
Atkinson, J. M., Hanover
Baker, Augustus L. L., 389 W. Blackwell st., Dover
Beaver, Jennie A. Dean, 44 Elm st., Morristown
Bird, Frank L., Netcong
Blanchard, Chas. L., 27 E. Blackwell st., Dover
Booth, Wm. K., 304 William st., Boonton
Bowers, F. Clyde, Prospect st., Mendham
Byrne, James A., 181 South st., Morristown
Carberry, Edward T., 67 S. Main st., Wharton
Collins, Laurence M., Greystone Park
Comeau, Geo. W., 415 Speedwell av., Morris Plains
Costello, Wm. F., 55 W. Blackwell st., Dover
Coultas, Aldo B., Madison
Curry, Marcus A., Greystone Park
Deichman, Chas. H., 39 Elm st., Morristown
Donovan, Joseph, N. J. State Hosp., Greystone Park
Douglass, Wm. C., 15 Olcott av., Bernardsville
Earp, Ruth, 15 Olcott av., Bernardsville
Eckhardt, Ralph A., 50 Green Village rd., Madison
*Emory, George B., Morristown
Failmezger, Theo. R., 17 Green Village rd., Madison
Ferriss, Ruth B., 10 DeHart st., Morristown
Frost, Inglis F., 181 South st., Morristown
*Galasso, Attilio, 1 Cutler st., Morristown
Geary, Daniel J., 40 Maple av., Morristown
Gibb, Wm. B., 26 Maple av., Morristown
Gilbertson, Robt. L., 39 Green Village rd., Madison
Glazebrook, Francis W., 37 Ogden pl., Morristown
Gordon, Chas. D., Mount Arlington
Gregory, Marie F., 50 Green Village rd., Madison
Hampton, Geo. R., Greystone Park
Harrington, John H., 126 E. Main st., Rockaway
Hatch, Harold S., Shonghum Mt. San., Morristown
Haven, Samuel C., 14 Elm st., Morristown
Heinig, Frank G., 124 Cornelia st., Boonton
Hiler, Stuart A., 62 Rockaway av., Rockaway
Hogan, Marshall D., 29 E. Blackwell st., Dover
Hubert, Antonio O., 131 E. Main st., Rockaway
Jenkins, Edward J., Mt. Pleasant av., Whippany
Johnston, Julian F., 17 Van Doren av., Chatham
King, Alden P., 44 W. Blackwell st., Dover
Knowles, Fredk. E., 103 Church st., Boonton
Kossmann, W. J., Long Valley
Krauss, Fletcher I., 201 Main st., Chatham
Kuite, Geo. B., 435 Speedwell av., Morris Plains
Lane, Arthur G., Greystone Park
Larson, Henry M., 35 Franklin st., Morristown
Lathrope, Geo. H., 32 Hamilton rd., Morristown
Mathews, Raymond H., 186 South st., Morristown
McElroy, Ervin, 20 Main st., Rockaway
McMahon, Bernard C., 18 DeHart st., Morristown
McMurray, Geo. B., N. J. State Hosp., Greystone P'k
Mial, Leonidas L., 38 Elm st., Morristown
Michell, Geo. E., 221 High st., Hackettstown
Mills, Clifford, 36 Maple av., Morristown
Musetto, Carmelo A., 135 Cornelia st., Boonton
Nicoll, Geo. L., 48 W. Blackwell st., Dover
Pinckney, Frank H., 186 South st., Morristown
Plume, Clarence A., Succasunna
Polakoff, Jos., Main st., Stirling
Pottinger, Wm. E., Midvale rd., Mountain Lakes
Prager, Bert A., 251 Main st., Chatham
Rice, Franklin W., 184 South st., Morristown

Rossi, Bartolomeo, 60 Park av., Madison
Ryan, Jos J., 55 Fairmount av., Chatham
Ryman, Merlin T., 4 N. Hillside av., Chatham
*Schmidt, Mathias, Denville
Schulman, Robt., Aurora Health Inst., Morristown
Scott, Harold R., 10 Speedwell av., Morristown
Seward, Frederick H., Madison
Sherman, Benj., Aurora Institute, Morristown
Sherman, Byron G., 52 Maple av., Morristown
Smith, Ivan B., 400 W. Blackwell st., Dover
Smith, Malcolm K., 22 Madison av., Morristown
Spencer, Alvan, 395 Blackwell st., Dover
Stage, Earl D., 11 James st., Morristown
Talmage, Wm. G., 389 W. Blackwell st., Dover
Teller, Daniel W., Jr., 26 Maple av., Morristown
Terreri, D. Joseph, 30 High st., Morristown
Teskey, Stanley, 10 Anderson rd., Bernardsville
Thomas, Thomas S., Jr., 26 Elm st., Morristown
Truax, Alfred J., 121 Church st., Boonton
Van Sickle, Albert W., Chester
Voorhies, Wm. S., Jr., Mendham
Voss, J. Landon, 21 Mt. Airy rd., Bernardsville
Ward, Albert J., 39 Elm st., Morristown
Washburn, P. C., Greystone Park
Williams, Louis E., 20 Madison av., Madison
Young, Geo. J., 23 Franklin pl., Morristown

Honorary Members

Mial, Leonidas L., Morristown

Transferred

Seward, Wm. H., to Essex County Medical Society
Conway, J. V., to Union County Medical Society
Reed, F. Grendon, to Essex County Medical Society

Number of active members and basis of representation, 88, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937.

OCEAN COUNTY (15)

Society organized October 28, 1903. Meets on second Wednesday of each month, except June, July, August and September. Annual Meeting in November.

President, Buermann, Robert, Lakewood

Vice-President, Hayden, Walter, Toms River

Secretary, Sickel, Emanuel, Lakewood

Treasurer, Obert, J. Edward, New Egypt

Reporter, Halbach, Robert McC., Toms River

Active Members

Buermann, Robt., 206 Madison av., Lakewood
Bunnell, Fredk. N., Barnegat
Carmona, Luis R., Tuckerton
*Disbrow, Harold D., Lakewood
Dodd, Wm. E., Ocean st. & Bay av., Beach Haven
Falkinburg, LeRoy W., Forked River
Frazee, Wm. H., Jr., 412 Main st., Toms River
Goldstein, Abraham, 404 Madison av., Lakewood
Green, Thomas J., New Egypt
Halbach, Robt. McC., 802 Main st., Toms River
Hayden, Walter G., 504 Main st., Toms River
Henriksen, Jay B., 422 River av., Point Pleasant
Herbener, Eugene G., 423 Third st., Lakewood
Ivory, Harry S., 616 Forman av., Point Pleasant
Lehmacher, Frank, 18 Central av., Lakewood
Menge, Carl H., 213 Washington st., Toms River
Obert, Josiah E., New Egypt
Sawyer, Blackwell, Washington st., Toms River
Sickel, Emanuel M., 220 Madison av., Lakewood
*Swan, Guy Howard, Beachwood
Szold, Norman F., 603 Monmouth av., Lakewood
Taylor, Raymond A., 58 Madison av., Lakewood
Thompson, Theodore F., 316 First st., Lakewood
Tilles, Samuel, 44 Sheridan av., Seaside Heights
Towbin, Adolph, 326 Third st., Lakewood
Willis, Herbert, Beach av. & Center st., Beach Hav'n
Witte, C. N., 711 Grove st., Point Pleasant

Associate Members

Schneider, Clinton R., 125 N. Green st., Tuckerton

Number of active members and basis of representation, 25, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937.

PASSAIC COUNTY (16)

Society organized January 14, 1844. Meets on the second Thursday evening of each month except June, July and August. Annual Meeting in October.

President, Dingman, Norman M., Paterson

First Vice-President, Vosburgh, Fred, Passaic

Second Vice-President, Shapiro, Louis G., Paterson

Secretary, Hall, Wayne W., Paterson

Treasurer, Leonard, Edward F., Paterson

Reporter, Johnsen, Sigurd W., Passaic

Active Members

Allen, Arthur A., 365 Park av., Paterson
Allen, James M., 657 Main av., Passaic
Armstrong, Robt. R., 114 Pennington av., Passaic
Ash, Frank W., 180 Carroll st., Paterson
Atkinson, James W., 603 S. Maple av., Glen Rock
Atwood, Edward A., 360 Park av., Paterson
Barlow, Frank A., 967 Madison av., Paterson
Barr, Joseph, 975 Madison st., Paterson
Becker, Geo. L., 646 E. 28th st., Paterson
Bender, Theodore, 666 Broadway, Paterson
Benjamin, Jos. Francis, 203 Goodwin av., Ridgew'd
Bergin, Jos. V., 315 Broadway, Paterson
Bergsma, Stuart, 257 Paulison av., Passaic
Berk, M. David, 320 Ramapo av., Pompton Lakes
Berkhout, P. G., 106 Haledon av., Prospect Park
Beshlian, Hagop K., 7 Lee pl., Paterson
Biczak, Arkad K., 27 Monroe st., Passaic
Birely, Morris F., 104 Avondale rd., Ridgewood
Bohl, Louis J., 329 Broadway, Paterson
Bongiorno, Henry D., 516 River st., Paterson
Bonynge, Henry A., 123 Prospect st., Ridgewood
Botbyl, Burt W., 927 Madison av., Paterson
Boylan, Lawrence B., 630 Main st., Paterson
Brancato, Peter, 17 Church st., Paterson
Brevoort, H. H., 54 Main st., Lodi

Bromberg, Chas. B., 107 Lexington av., Passaic
Brooks, Sidney, 62 12th av., Paterson
Butterfield, Arey A., 657 Main av., Passaic
Cantrell, Wm. C., 709 Main av., Clifton
Carlisle, John H., 129 Prospect st., Passaic
Carlough, David J., 426 Ellison st., Paterson
Catanzaro, Francesco, 151 Jefferson st., Passaic
Chapnick, Maurice M., 117 Paterson st., Paterson
Chase, Wm. E., 585 Main av., Passaic
Chester, Saul W., 634 Broadway, Paterson
Chrisman, Irving, 408 Ellison st., Paterson
Ciccone, Anthony C., 389 Grand st., Paterson
Clay, Arthur T., 351 Totowa av., Paterson
Cogan, Henry, 128 Carroll st., Paterson
Cohen, Julian, 475 Park av., Paterson
Cohen, M. Marvin, 137 Graham av., Paterson
Cole, Lewis F., 242 Broadway, Passaic
Connolly, Jos. P., 64 Hamilton st., Paterson
Connolly, Thos. V., 56 Hamilton st., Paterson
Coppola, Edward A., 447 Lexington av., Clifton
Cortese, Alvin E., 26 Ward st., Paterson
Cotton, Norman T., 219 Graham av., Paterson
Cremens, John F., 144 Carroll st., Paterson
Crounse, David R., 84 Broadway, Passaic
Dawson, Harry, 618 E. 24th st., Paterson
DeBell, Peter J., 239 Burgess pl., Passaic
Deich, Samuel R., 162 Lexington av., Passaic
Delario, Anthony J., 294 Broadway, Paterson
DeMattia, Michael, 18 Ward st., Paterson
Del Mauro, Alphonse, 417 21st st., Paterson
DeRosa, Armand, 290 Union Blvd., Totowa
De Rosa, John, 150 Fair st., Paterson
Desmet, Victor F., 324 Broadway, Paterson
DeYoe, Leon E., 602 Broadway, Paterson
Dingman, Norman M., 330 Broadway, Paterson
Drake, Daniel E., Greenwood Lake rd., Newfoundl'd
Duncan, Owsley B., 606 26th st., Paterson
Dunning, Walter L., 533 River st., Paterson
Durant, Harold J., 485 Park av., Paterson
Dwyer, Henry E., 261 Madison st., Passaic
Dwyer, Wm. A., 99 Park av., Paterson
Eilkraut, Edward C., 82 President st., Passaic
Ehrenfeld, Edward, 115 Lexington av., Passaic
Ehrenfeld, Irving, 115 Lexington av., Passaic
Ekings, Frank P., 221 Broadway, Paterson
Feigenoff, Israel, 420 Broadway, Paterson
Fisher, Samuel, 808 Madison av., Paterson
Flitcroft, Wm., 510 River st., Paterson
Gallo, James S., 32 Zabriskie st., Paterson
Giambra, Sante M., 666 Broadway, Paterson
Gillson, Hugh V., 21 Lee pl., Paterson
Gilson, John T., 170 Broadway, Paterson
Ginsburg, Samuel, 227 Paulison av., Passaic
Glasgow, Thomas M., 120 Passaic av., Passaic
Gochman, Harry M., 166 Hamilton av., Paterson
Goldenberg, Raphael R., 575 Broadway, Paterson
Golding, Harry N., 180 Carroll st., Paterson
Gordon, Abel, 616 Main av., Passaic
Gordon, Osher, 119 Lexington av., Passaic
Gormley, Cyrus M., 6 Roberts st., Butler
Gould, John H., 266 Van Houten st., Paterson
Graham, Archibald F., 42 Park av., Paterson
Graham, Theodore K., 278 Park av., Paterson
Greengrass, Jacob J., 146 Broadway, Paterson
Hagen, Orville R., 266 Van Houten st., Paterson
Hall, Wayne W., 266 Van Houten st., Paterson
Hambright, Arthur M., 266 Van Houten st., Paterson
Harreys, Chas. W., 714 Broadway, Paterson
Holmes, Thomas J., 151 Fair st., Paterson
Holt, Herman H., 258 Graham av., Paterson
Hughes, John V., 657 Main av., Passaic
Ianacone, John A., 310 Fifth av., Paterson
Irving, Albert, 318 Howard av., Radburn-Fair Lawn
Ives, Edwin I., 24 Stevens av., Little Falls
Jahn, Albert G., 657 Main av., Passaic
Jani, Frank F., 297 Lexington av., Passaic
Jarmulowsky, Harry, 181 E. 33rd st., Paterson
Jehl, Joseph R., 305 Clifton av., Clifton
Joelson, Morris S., 577 Broadway, Paterson
Joffe, Sidney H., 556 E. 28th st., Paterson
Johnsen, Sigurd W., 49 Passaic av., Passaic
Joseph, Morris, 271 Lexington av., Passaic
Keating, Chas. A., 177 Ellison st., Paterson
Keller, Franklin J., 297 Diamond Br. av., Hawth'rne
Kennedy, Eugene T., 413 Wanaque av., Pompt'nL'k's
Keppler, Chas., Jr., 723 Allwood rd., Clifton
Kim, Gay B., 528 Totowa rd., Totowa
Kinney, Burton O., 41 Lincoln av., Little Falls
Kleiner, Samuel, 162 Hamilton av., Paterson
Koenig, Bertram M., 306 Broadway, Paterson
Koerber, Geo., 136 Prospect st., Passaic
Kuhl, John P., 38 Main st., Butler
Laauwe, Harold W., 198 Haledon av., Prospect Park
Labash, Chas., 83 Quincy st., Passaic
Landaw, Louis, 669 Broadway, Paterson
Lawrence, E. D., 365 Union av., Paterson
Lemay, Albert T., 384 15th av., Paterson
Leonard, Edward F., 771 Madison av., Paterson
Levendusky, Daniel E., 52 Market st., Passaic
Levine, David B., 647 Broadway, Paterson
LeVine, Israel, 215 Broadway, Paterson
Levine, Sidney C., 459 Park av., Paterson
Levinsohn, Sandor A., 584 Broadway, Paterson
Levy, Herman, 219 Lexington av., Passaic
Linares, Angelo C., 208 Market st., Paterson
Lobsenz, Nathan P., 294 Broadway, Paterson
Lomauro, James R., 149 Lexington av., Passaic
Low, Donald B., 529 Broadway, Paterson
Lucas, Henry H., 266 Van Houten st., Paterson
Lucent, Santos B., 2 First st., Little Falls
Luksteid, Casimir J., 282 Broadway, Paterson
McBride, Andrew F., 30 Church st., Paterson
McCamey, Kenneth E., 612 E. 29th st., Paterson
McCarthy, Geo. L., 496 Union av., Paterson
McCoy, John C., 292 Broadway, Paterson
McCue, John B., 912 Lincoln av., Pompton Lakes
McDede, Frank F., 922 Main st., Paterson
McDonald, Richard J., 294 Broadway, Paterson
McPherson, M. E., 141 Diamond B'dge av., Hawth'ne
MacAlister, Wm. W., 333 Van Houten st., Paterson
MacGuffie, Robt. N., 657 Main av., Passaic
MacGregor, Allan W., 379 Ellison st., Paterson
Maclay, Jos. A., 239 Broadway, Paterson
MacMillan, Chas. W., 23 Passaic av., Passaic
Maffongellie, Joseph A., 494 River st., Paterson
Magennis, Bryan C., 267 Park av., Paterson
Manly, Thomas E., 360 Park av., Paterson
Maps, Howard L., 53 Passaic av., Passaic
Marini, Dominick, 40 Henry st., Passaic
Markel, Albert G., 320 Broadway, Paterson
Markowitz, Louis, 16 Church st., Paterson
Marrocco, Wm. A., 47 Ward st., Paterson
Marsh, Elias J., 400 Van Houten st., Paterson
Masucci, Alberico, 34 Ward st., Paterson
Matthews, Leonard M., 657 Main av., Passaic
Meier, Wm. U., 1062 Ringwood av., Haskell
Meloney, Lester F., 156 Second st., Clifton
Mendelsohn, David H., 576 Broadway, Paterson
Meneve, Alfred D., 87 Bridge st., Paterson
Meyers, Francis R., 627 E. 24th st., Paterson
Michela, Luigi S., 206 Carroll st., Paterson
Mills, Alvah V., Lindsley rd., Little Falls
Mitchell, Chas. R., 311 Broadway, Paterson
Morrill, James P., 310 Broadway, Paterson
Moscoe, Harry A., Main st., Lincoln Park
Munn, Chas. J., 48 Smith st., Paterson
Neer, Wm., 245 Broadway, Paterson
Nemirow, Martin, 234 Lexington av., Passaic
Nesbitt, Eliz., No. Jer. Training School, Little Falls
Norval, Wm. A., 419 Main st., Paterson

Notkin, Meyer, 351 Van Houten st., Paterson
Nye, Howard H., 174 Carroll st., Paterson
O'Brian, Dennis M., 154 Lexington av., Passaic
O'Brian, Jeremiah H., 204 Madison st., Passaic
Okin, Irving, 165 Passaic av., Passaic
Oram, Jos. H., 495 Broadway, Paterson
Pal, Darbari R., 32 Clark st., Paterson
Palmer, Francis R., 249 Lexington av., Passaic
Parrk, M. Benj., 360 Park av., Paterson
Patella, Fulvio, 232 Broadway, Paterson
*Payawall, Juan L., 26 Lake st., Ramsey
Pearlman, Saul J., 210 Lexington av., Passaic
Pelusio, August N., 269 Carroll st., Paterson
Pernetti, Anthony M., 715 Broadway, Paterson
Phelps, James E., 203 Park av., Paterson
Plinke, Fritz, W., 159 Lexington av., Passaic
Polizzotti, Joseph L., 193 Park av., Paterson
Polowe, David, 558 E. 27th st., Paterson
Prince, Robt. A., 567 Broadway, Paterson
Raab, Michael, 111 Lexington av., Passaic
Radest, L. J., 158 Hamilton av., Paterson
Rauschenbach, Paul E., 225 Broadway, Paterson
Reeves, Ernest, 195 Lexington av., Passaic
Reynolds, Earle C., 655 Main av., Passaic
Reynolds, Harry C., 657 Main av., Passaic
Richards, Paul S., 1 Main st., Butler
Rinzler, Harry G., 127 Van Houten av., Passaic
Roemer, Jacob, 213 Broadway, Paterson
Rothman, Theodore, 268 Park av., Paterson
Ruocco, Wm. B., 416 River st., Paterson
Ryan, John N., 158 Lexington av., Passaic
Salzman, Nathan, 714 Broadway, Paterson
Sanfacon, Thomas A., 340 Park av., Paterson
Santangelo, Emil L., 400 Broadway, Paterson
Schultz, Augustin M., 379 Union av., Paterson
Scribner, Chas. H., Hamburg Trnpk., R.D. 1,P't'rs'n
Shapiro, Louis G., 375 Broadway, Paterson
Shippee, David N., 648 Ringwood av., Wanaque
Shippee, J. N., 648 Ringwood av., Wanaque
Shulman, Abraham, 528 E. 29th st., Paterson
Simon, Morris L., 174 Washington pl., Passaic
Siveke, John, 106 Lexington av., Passaic
Slaff, Florence, 16 Grove ter., Passaic
Sloan, Samuel L., 182 Belmont av., Passaic
Smith, Elroy W., 655 Main av., Passaic
Smith, Leon A., 655 Main av., Passaic
Spickers, Wm., 6 Church st., Paterson
Stark, Jacob, 645 Broadway, Paterson
Stein, Harold M., 227 W. Broadway, Paterson
Steinberg, Benj. L., 534 Main st., Singac
Stokes, James S., 85 Park av., Paterson
Stoltz, Raymond R., 23 Passaic av., Passaic
Sucoff, Moses C., 158 Hamilton av., Passaic
Sullivan, Wm. M., Jr., 43 Passaic av., Passaic
Surnamer, Isaac, 345 Broadway, Paterson
Sutherland, Wm. W., 320 Broadway, Paterson
Szymanski, John J., 616 Main av., Passaic
Taber, Leslie R., 266 Van Houten st., Paterson
Tellman, Daniel H., 120 Lexington av., Passaic
Temple, Arthur H., 164 Jefferson st., Passaic
Terhune, Percy H., 171 Paulison av., Passaic
Thorne, Wm. P., 254 Main st., Butler
Throu, Leopold E., 586 E. 29th st., Paetrson
Todd, Francis H., 83 Auburn st., Paterson
Tompkins, Wm., 105 Fairmount rd., Ridgewood
Tuers, Geo. E., 418 Park av., Paterson
Tweddel, Geo. K., 239 Broadway, Paterson
Udinsky, Hyman J., 29 Passaic av., Passaic
Vanderbeek, Andrew B., 174 Broadway, Paterson
Vanderbeek, Andrew B., Jr., 456 Park av., Paterson
Van Eerde, Albert, 339 Lafayette av., Hawthorne
Vander Clock, Cornelius, 23 Passaic av., Passaic
Van Riper, Arthur W., 607 Main av., Passaic
Van Schott, Gerald J., Jr., 245 Lexington av., Pas'c
Van Urk, Freak. T., 663 Main av., Passaic
Van Winkle, John S., 297 Broadway, Paterson
Vosburgh, Fred, 61 Passaic av., Passaic
Vreeland, Ralph J., 266 Van Houten st., Paterson
Walker, Harold G., Everett av., Wyckoff
Walton, Gordon G., 17 Church st., Paterson
Warburton, Jack C., 277 Broadway, Paterson
Warren, David E., 265 Gregory av., Passaic
Warren, Jacob, 308 18th av., Paterson
Wassing, Hans, 695 Broadway, Paterson
Weinert, Henry V., 128 Market st., Passaic
Weintraub, Wm. L., 400 Broadway, Paterson
Westerhoff, Peter D., Jr., 116 Auburn st., Paterson
Willard, Harry S., 266 Van Houten st., Paterson
Wilkinson, Boyd E., 266 Van Houten st., Paterson
Williams, Hiram, 230 Lexington av., Passaic
Winters, Walter M., 288 Broadway, Paterson
Wishnack, Meyer, 318 Broadway, Paterson
Wolfson, Harry, 324 Broadway, Paterson
Wry, Dean A., 234 Dayton av., Clifton
Yachnin, Samuel C., 34 Grove st., Passaic
Yager, Jacob A., 6 Church st., Paterson
Yates, John S., 414 Ellison st., Paterson
Yolken, Harry, 246 E. 31st st., Paterson
Zalewski, I. J., 125 Market st., Passaic

Associate Members

Reading, H. E., 538 E. 29th st., Paterson

Number of active members and basis of representation, 273, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937.

SALEM COUNTY (17)

Society organized May 4, 1880. Meets on the second Friday in February, April, October and December. Annual Meeting in April. Social meeting in May.

President, Dunn, J. S., Salem
Vice-President, Mackes, C. B., Woodstown
Secretary-Treasurer, Green, David W., Salem
Reporter, Hummel, L. C., Salem

Active Members

Bramble, Halsey S., Front & Chestnut sts., Elmer
Church, Franklin H., 86 W. Broadway, Salem
Davison, C. Spencer, 7 Chestnut st., Salem
Davison, Wilbur S., Pennsville
Dunn, John S., 75 Market st., Salem
Evans, E. E., 12 Ziegler ter., Pennsgrove
Fleming, Chas. L., 42 W. Main st., Pennsgrove
Green, David W., 69 Market st., Salem
Hilliard, Wm. T., 105 Market st., Salem
Hummel, Ira L., 109 W. Broadway, Salem
James, Wm. H., Main st., Pennsville
Lummis, Clarence P., 40 Delaware av., Pennsgrove
Mackes, Claude B., 46 N. Main st., Woodstown
Miller, Lewis H., 37 S. Main st., Woodstown
Perry, Frank L., 13 East av., Woodstown
Prigger, Edward R., 39 Main st., Pennsgrove
Summerill, John M., Maple av., Pennsgrove
Suter, Harry F., 49 W. Main st., Pennsgrove
Weigel, C. B., 328 E. Broadway, Salem
Zappala, John, 47 W. Main st., Pennsgrove

Transferred

Lummis, Clarence P., from Cumberl'd Co. Med. Soc.

Number of active members and basis of representation 20, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937.

SOMERSET COUNTY (18)

Society organized May 21, 1816. Meets on the second Thurday in February, April, June, October and December. Annual Meeting in June.

President, Gray, W. B., No. Plainfield

Vice-President, Sferra, A. F. W., Bound Brook

Secretary, Fritts, Lewis C., Somerville

Treasurer, Lawton, A. A., Somerville

Reporter, Pigott, A. W., Skillman

Active Members

Adams, Rayford K., Lakeside Lodge, Skillman
Albrecht, Wm. J., 25 N. Bridge st., Somerville
*Anderson, John E., Neshanic
Barbour, Geo. E., 118 W. High st., Somerville
Beekman, John B., Bedminster
Bendix, Gerard M., 4 W. Somerset st., Raritan
Blank, Sam'l, N. J. State Vil. for Epileptics, Skillm'n
Borow, Benj., 574 Watchung av., Bound Brook
Borow, Henry, 507 Church st., Bound Brook
Borow, Louis S., 934 Park st., Bound Brook
Borow, Maurice, 507 Church st., Bound Brook
Brittain, Elmore G., 4 E. High st., Bound Brook
Cooley, Roger L., Dunellen
Cooper, Jos. H., East Millstone
Craig, Henry A., 315 William st., Somerville
Crawford, John W., Bedminster
Day, Hayward F., 37 Craig pl., No. Plainfield
Dundon, Arthur H., 135 Somerset st., Plainfield
East, Isaac C., Skillman
Edelberg, Sidney S., 18 Hamilton st., Bound Brook
Ely, Lancelot, 128 W. High st., Somerville
Falcone, N. A., 27 Duer st., No. Plainfield
Field, Frank L., Far Hills
Flint, Edgar T., 44 E. Somerset st., Raritan
Flynn, Thomas H., 41 High st., Somerville
Francis, Adaline M., 80 West End av., Somerville
Fritts, Lewis C., 62 E. High st., Somerville
Gray, W. B., 121 Somerset st., No. Plainfield
Greenberg, Geo. A., 55 W. Main st., Somerville
Halsted, Chas. F., 40 Grove st., Somerville
Hamblin, Donald O., Calco Chem. Co., Bound Brook
Hegeman, Runkle F., 161 W. High st., Somerville
Hird, Emerson F., 118 E. Maple st., Bound Brook
Husted, Samuel H., Neshanic Station
Kay, Clarence R., Peapack
Knight, Augustus S., Far Hills
Lawton, A. Anderson, 15 N. Bridge st., Somerville
Levy, Abram, Bound Brook
Long, Wm. H., 40 South Bridge st., Somerville
Lovejoy, James L., 224 Somerset st., Bound Brook
Lukats, Elmer J., State Village for Epil., Skillman
Mangelsdorff, Arthur F., Calco Chem. Co., B. Brook
McConaughy, Francis, 1 E. High st., Somerville
M igh, Josiah, Bernardsville
Pigott, Albert W., Skillman
Pogoloff, Samuel H., Manville
Reale, Nich. P., Weiss Bldg., S. Main st., Manville
Renner, Dan S., Skillman
Robinson, John T., 598 Watchung av., Bound Brook
Sferra, Alfred F. W., 125 Hamilton st., Bound Brook
Shirlock, Marg. E., Vineland Train. School, Vineland
Smalley, Mahlon C., Gladstone
*Stillwell, Aaron, Somerville
Thomas, Mary L., Skillman
Wallach, Bernard, 74 Watchung av., No. Plainfield
Wild, Fredk. A., 111 E. High st., Bound Brook
Young, James L., 68 Mountain av., Somerville

Transferred

von Haitinger, Kalman, to Passaic Co. Med. Soc.
Rothey, K. B., to Cape May Co. Med. Society

Number of active members and basis of representation, 55, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937.

SUSSEX COUNTY (19)

Society organized August 22, 1829. Meets bi-monthly, September to May, inclusive, at call of President. Annual Meeting on the second Tuesday in May.

President, Smith, Warren H., Newton

Vice-President, Spurgeon, D. L., Newton

Secretary, Drake, Leo, Franklin

Treasurer, Eddy, Lester R., Sussex

Reporter, Groeschel, A. H., Sussex

Censor, Roy, B. W., Sussex

Active Members

Burn, Victor C., Newton
Cole, Blase, Newton
Coleman, Jos. G., Hamburg
Drake, Leo B., 47 Main st., Franklin
Eddy, Lester R., Sussexx
Groeschel. August H., 31 Bank st., Sussex
*Jacob, Albert, Sparta
Johnson, Geo. F., Branchville
Kirschner, M. T., Vernon
Landes, Edwin W., Stillwater
Longnecker, John E., Jr., Sparta
McCall, Jesse, 12 Church st., Newton
Morrison, Fred'k H., Newton
Pellet, Thomas L., Hamburg
Rothman, Benj. G., 21 Main st., Sussex
Roy, Bert W., Sussex
Scott, Fredk. J., Franklin
Smith, Warren H., 91 Main st., Newton
Spencer, James H., Jr., 23 Hospital rd., Franklin
Spurgeon, Dorsett L., 19 Church st., Newton
Zuck, John A., Main st., Stanhope

Honorary Members

Cole, Martin, Hainesville
Pellet, Jackson B., Hamburg

Number of active members and basis of representation, 20, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937.

UNION COUNTY (20)

Society organized June 7, 1869. Meets on the second Wednesday of February, April, October and December. Annual Meeting in October.

President, Weigel, Elmer P., Plainfield
Vice-President, Abel, Henri, Elizabeth
Secretary, Armstrong, Lorrimer B., Westfield
Treasurer, Hoover, Alden R., Elizabeth
Repoter, Carpenter, Cedric C., Summit

Active Members

Abel, Henri E., 339 Union av., Elizabeth
Ackerman, Arthur F., 129 Summit av., Summit
Armstrong, Lorrimer B., 121 S. Euclid av., Westf'ld
Arthur, Frances H., 138 Westfield av., Elizabeth
Austin, Thomas R., 16 Alden st., Cranford
Babbitt, Hugh M., Jr., 101 W. 7th st., Plainfield
Baker, Raymond D., 52 De Forest av., Summit
Baron, Leo E., 509 N. Wood av., Linden
Barr, Abraham H., 830 Wood av., Linden
Baruch, Rudolf J., 414 Elizabeth av., Elizabeth
Beisler, Lawrence G., 1528 N. Broad st., Hillside
Bensley, Maynard G., 129 Summit av., Summit
Berenson, Samuel J., 414 Elizabeth av., Elizabeth
Berman, Leonard, 155 Summit av., Summit
Berry, Clarence H., 129 Summit av., Summit
Birrell, Russell G., 554 Westminster av., Elizabeth
Bishop, Carl, 831 Madison av., Plainfield
Black, Max, 1192 St. George av., Linden
Blair, Thomas D., 414 Park av., Plainfield
Bloch, Harry, 200 E. Jersey st., Elizabeth
Blumberg, Jack, 504 Westminster av., Elizabeth
Blythe, Rowland P., 30 Springfield av., Cranford
Booth, Walter S., 318 Grier av., Elizabeth
Boozan, Wm. E., 1139 E. Jersey st., Elizabeth
Bourns, Edward G., 126 Harrison av., Westfield
Bowles, Harry H., 36 Woodland av., Summit
Boyes, James G., 1326 Chetwynd av., Plainfield
Breslow, Alexander E., 12 W. Milton av., Rahway
Brokaw, Christopher A., 1405 North av., Elizabeth
Brook, H. F., 417 W. Broad st., Westfield
Brown, Lawrence G., 173 Madison av., Elizabeth
Brown, Wm. H., 29 Third st., Elizabeth
Bruning, Richard H., 435 Westminster av., Elizabeth
Bunting, P. Du Bois, 712 N. Broad st., Elizabeth
Burritt, Norman W., 30 Beechwood rd., Summit
Butenas, Jos. J., 300 First av., Elizabeth
Callahan, Edward J., 124 St. Paul st., Westfield
Canright, Cyril M., 2 Berkeley pl., Cranford
Cantini, Raphael S., 147 E. 7th st., Plainfield
Card, Chas. F., 100 W. Milton av., Rahway
Carlisle, J. M., 106 Miln st., Cranford
Carpenter, Cedric C., 129 Summit av., Summit
Casilli, Arturo R., 618 Newark av., Elizabeth
Chaiken, Louis H., 1024 E. Jersey st., Elizabeth
*Chapman, A. L., Rahway
Chapman, Otis P., 125 Broad st., Elizabeth
Childers, Robt. J., 604 Park av., Plainfield
Cole, Walter H., Jr., 116 Chilton st., Elizabeth
Comunale, Anthony R., 1709 Irving st., Rahway
Conway, James V., 673 Jefferson av., Elizabeth
Corbusier, Harold D., 614 Park av., Plainfield
Crabtree, Loren H., 142 Bellevue av., Elizabeth
Crane, Norman T., 147 E. 7th st., Plainfield
Cronin, Francis J., 730 South st., Elizabeth
Currie, Norman W., 508 Central av., Plainfield
Daron, Simeon, 31 Lincoln park, Newark
Davidson, Edwin N., 102 E. Elm st., Linden
Davidson, Maurice M., 128 Grant av., E. Roselle Pk.
Davis, F. Cleveland, 129 Summit av., Summit
Davis, Stanton H., 212 E. 7th st., Plainfield
Day, Willis, B., 407 E. 7th st., Plainfield
DeCesare, Ferdinand J., 500 Walnut st., Roselle Pk.
Decker, Chas. T., 178 Elm st., Westfield
De Freitas, Clement, 423 W. 4th st., Plainfield
Dengler, Henry P., Morris av., Springfield
Dennin, Jos. W., 308 Chestnut st., Roselle
Diamond, Jos. G., 512 W. Front st., Plainfield
Disbrow, Geo. W., Overlook Hospital, Summit
Drury, Alfred J., 268 E. 3rd av., Roselle
du Busc, Lawrence C., 399 Westfield av., Elizabeth
Durrah, Fred F., 310 Plainfield av., Plainfield
Eason, Samuel W., 48 De Forest av., Summit
Edgar, Malcolm S., 129 Summit av., Summit
Ehrlich, Maxwell, 513 Westfield av., Elizabeth
Esty, Geoffrey W., 629 E. Broad st., Westfield
Ewart, Eli W., 531 E. Broad st., Westfield
Feleppa, Edward E., 239 Morris av., Summit
Fiedler, Michael, 247 Crawford ter., Union
Fitch, Thomas S., 916 Park av., Plainfield
Fordyce, Claude P., 921 C. st., Lincoln, Nebraska
Fort, Wm. B., 147 E. 7th st., Plainfield
Foster, Frank L., 320 Springfield av., Cranford
Franklin, Jos. E., 127 Westfield av., Elizabeth
Freeman, Roy M., 826 N. Wood av., Linden
Friedburg, Geo. H., 1108 Anna st., Elizabeth
Frohwein, Ida H., 125 Morristown rd., Elizabeth
Funk, Jos., 615 Elizabeth av., Elizabeth
Gallaway, Geo. F., 109 W. Milton av., Rahway
Geary, Paul, 923 Park av., Plainfield
Gelber, Isaac, 2052 Morris av., Union
Gerendasy, Julius, 956 E. Jersey st., Elizabeth
Gibb, Alice S., 339 Union av., Elizabeth
Giglio, Alphonsus S., 626 Elizabeth av., Elizabeth
Gilpin, Fletcher, 118 North av., W., Cranford
Gittelman, Morton, 1028 E. Jersey st., Elizabeth
Glaser, Emanuel, 360 Linden av., Elizabeth
Glass, Benj. E., 609 Watchung av., Plainfield
Glasston, Hyman M., 628 N. Wood av., Linden
Golden, Wm. M., 70 Irving st., Rahway
Goldfield, Harold H., 225 E. Jersey st., Elizabeth
Goldmacher, Herman B., 555 S. Broad st., Elizabeth
Goldstein, Herman H., 318 W. Jersey st., Elizabeth
Gonczy, Edward J., 538 Jersey av., Elizabeth
Gorczyca, Albert G., 538 S. Broad st., Elizabeth
*Green, James S., 463 N. Broad st., Elizabeth
Greenberg, Max., 35 Gesner st., Linden
Gregory, Roy A., 161 Crescent av., Plainfield
Griesemer, Zadoc L., 1145 E. Jersey st., Elizabeth
Griswold, Merton L., Jr., 949 Park av., Plainfield
Guidi, Guido M., 212 Christine st., Elizabeth
Hackett, Edward J., 566 Westfield av., Westfield
Hall, Winthrop H., 400 Elm st., Westfield
Hallock, Wilton J., 25 Plainfield av., Berkley Heights
Hanrahan, James M., 1144 E. Broad st., Elizabeth
Hansen, Harry, 831 Madison av., Plainfield
Hanson, Carl G., 116 Eastman st., Cranford
Haseltine, Sherwin L., 125 Broad st., Elizabeth
Herrington, Lee R., Jr., 603 E. Broad st., Westfield
Higgins, Thomas F., 146 Reid st., Elizabeth
Hipple, Percy L., Jr., 230 Walnut st., Roselle
Hnat, Fredk., 471 Madison av., Elizabeth
Hoffman, Chas. A., 302 E. 7th st., Plainfield
Holland, Reuben J., 1026 Chandler av., Linden
Holmes, Grace W., 1077 E. Jersey st., Elizabeth
Holt, Evelyn, 118 Summit av., Summit
Holtzman, Michael, 167 Second st., Elizabeth
Hoover, Alden R., 5 Prince st., Elizabeth
Horre, Geo. W., 203 W. Jersey St., Elizabeth
Hubbard, Harry V., 121 E. 7th st., Plainfield
Hughes, Frederic J., 706 Park av., Plainfield
Hunt, Thomas F., 528 Monroe av., Elizabeth
Hutton, Fredk. T., 1012 Park av., Plainfield

Imbleau, Joseph E., 2106 Morris av., Union
Iserman, Michael, 209 Westfield av., Elizabeth
Jackson, Geo. H., 1030 Pine st., Union
Jacobs, Alan L., 2130 Morris av., Union
Johnson, Harold F., 734 Park av., Plainfield
Jones, Herbert E., 47 Elm st., Elizabeth
Jones, Lewis H., 139 Grant av., Roselle Park
Kapp, Carl G., 440 Westminster av., Elizabeth
Karshmer, Ernest E., 927 S. Wood av., Linden
Keeney, Cadwell B., 137 Summit av., Summit
Kemper, Harry E., 224 Monmouth rd., Elizabeth
Kinch, Fredk. A., 267 E. Broad st., Westfield
Knauer, Geo., 930 Elizabeth av., Elizabeth
Knepper, Orcena F., 149 Crescent av., Plainfield
Konzelman, Henry J., 65 King st., Hillside
Kramer, Douglas W., 822 Park av., Plainfield
Krans, Clara M., 920 Park av., Plainfield
Krans, Edward S., 920 Park av., Plainfield
Kreutz, Paul J., 363 Union av., Elizabeth
Kuchlewski, Edward J., 130 Third st., Elizabeth
Kushner, Alexander, 208 W. Milton av., Rahway
Kyle, Ernest I., 1165 Park av., Plainfield
Labow, Jos. J., 1063 E. Jersey st., Elizabeth
Ladas, Geo. 305 Cherry st., Elizabeth
Laird, Geo. S., 125 Central av., Westfield
Lamy, Anthony W., 560 Newark av., Elizabeth
Lance, Elton W., 125 W. Milton av., Rahway
Larrabee, Callie H., 14 Kent Place Blvd., Summit
Lathrop, Frederic W., 507 Park av., Plainfield
Laurie, Andrew L., 664 Newark av., Elizabeth
Lawrence, Wm. H., 129 Summit av., Summit
Leggett, Lindley H., Jr., 330 E. Broad st., Westfield
Leggett, Thomas H., Jr., 706 Park av., Plainfield
Lepree, Jos. A., 371 Morris av., Elizabeth
Lerman, Irving, 1024 E. Jersey st., Elizabeth
Lewis, Albert, 41 Retford av., Cranford
Lieberman, David P., 1063 North av., Elizabeth
Lieberman, Milton L., 101 Pershing av., Roselle Pk.
Linke, James J., 245 E. Front st., Plainfield
Livengood, Horace R., 587 Westminster av.,Eliz'b'th
Llull, Gabriel J., 271 Morris av., Springfield
Losada, Camella A., 19 Prospect st., Summit
Lowell, Milton E., 434 Summit av., Westfield
Lufburrow, Chas. B., 441 W. Front st., Plainfield
Lyerly, James M., 1116 Putnam av., Plainfield
Lynch, Edward T., 748 Livingston rd., Elizabeth
McCallion, Wm. H., 722 Westminster av., Elizabeth
McClintock, Elsie, 1439 Maple av., Hillside
McGinn, Wm. J., 1913 Westfield av., Scotch Plains
Maggio, Rosario J., 550 Carlton rd., Westfield
Malatesta, Chas. S., 741 Kingston av., Plainfield
Marts, Geo. H., 956 Park av., Plainfield
*McElhinney, Dennis R., Elizabeth
Meineke, Wm. C., Jr., 820 Chestnut st., Roselle
Merlo, Francis A., 210 Murray st., Elizabeth
Miller, Robt. M., 382 Springfield av., Summit
Milligan, Robert S., 239 Morris av., Summit
Mills, Stephen D., 132 S. Euclid av., Westfield
Minnella, Thomas J., 12 Russell pl., Summit
Moister, Roger W., 7 Norwood av., Summit
Montfort, Robt. J., 1051 E. Jersey st., Elizabeth
Moress, Edward J., 1551 Maple av., Hillside
Morris, Thomas M., 503 Park av., Plainfield
Morris, Watson B., 193 Morris av., Springfield
Munger, Ray T., 727 Watchung av., Plainfield
Murphy, Herschel S., 320 Chestnut st., Roselle
Murray, Norman L., 129 Summit av., Summit
Naidorff, Saul A., 404 W. 7th st., Plainfield
Newman, Louis G., 316 E. Broad st., Westfield
Nittoli, Rocco M., 660 E. Jersey st., Elizabeth
Novello, Jos. A., 641 Second av., Elizabeth
Obester, Gabriel E., 646 Madison av., Elizabeth
Oderr, Charles, 121 S. Euclid av., Westfield
Orton, Carlton B., 321 E. Second av., Roselle
Orton, Geo. Lee, 98 Elm av., Rahway
Osher, Morris M., 194 Martine av., N. Fanwood
Paulson, Arch M., 160 E. 7th st., Plainfield
Pearl, Sydney S., 545 Rahway av., Elizabeth
Peters, Richard C., 963 Park av., Plainfield
Phelan, Walter F., 124 Chilton st., Elizabeth
Poleshuck, Rubin, 127 Hollywood av., Hillside
Polk, Chas. C., 114 E. 7th av., Roselle
Prout, Thomas P., 19 Prospect st., Summit
Quinn, Stephen T., 1143 E. Jersey st., Elizabeth
*Randolph, John N., Rahway
Read, Jessie D., 519 Lenox av., Westfield
Reich, Jerome J., 1410 Maple av., Hillside
Reiner, Jacob, 811 N. Broad st., Elizabeth
Relyea, Geo. McD., 129 Summit av., Summit
Ripps, Maurice L., 410 Elmora av., Elizabeth
Robertson, Grace M., 650 W. 7th st., Plainfield
Rosenstein, Saivel L., 2120 Springf'ld av.,VauxHall
Runnells, J. E., Bonnie Burn Sana., Scotch Plains
Sadoff, Joseph, 116 Elmora st., Elizabeth
Salvati, Leo H., 275 Orchard st., Westfield
Samuels, Sol L., 612 W. Front st., Plainfield
Satulsky, E. M., 544 Jersey av., Elizabeth
Schilling, Anthony B., 727 Jefferson av., Elizabeth
Schlein, David, 28 Price st. E., Linden
Schlichter, Chas. H., 556 N. Broad st., Elizabeth
Schwartz, Samuel H., 414 Park av., Plainfield
Schweizer, Roman G., 36 Summit rd., Elizabeth
Sell, Fredk. W., 167 W. Emerson av., Rahway
Senerchia, F. F., Jr., 604 Westminster av., Elz'b'th
Seybold, Arthur D., 302 E. 7th st., Plainfield
Shack, Maxwell H., 226 Morris av., Springfield
Shangle, Milton A., 34 Prince st., Elizabeth
Sherman, Samuel H., 81 Elmora av., Elizabeth
Shirrefs, Russell A., 55 Broad st., Elizabeth
Singer, Bella, 406 Elmora av., Elizabeth
Sly, John L., 382 Springfield av., Summit
Spivack, David, 944 E. Jersey st., Elizabeth
Squires, Chas. A., 602 Central av., Plainfield
Stanton, Nathaniel B., 734 Park av., Plainfield
Staub, Emil M., 531 E. Broad st., Westfield
Steele, Stephen, 10 W. Gibbons st., Linden
Stein, Emil, 607 Park av., Elizabeth
Stein, Geo. H., 406 Elmora av., Elizabeth
Stein, Isadore, 210 Elizabeth av., Elizabeth
Stein, Martin H., 163 Second st., Elizabeth
Stephenson, G. A., 145 Summit av., Summit
*Stern, Arthur, 224 E. Jersey st., Elizabeth
Steuart, David F., 11 De Barry pl., Summit
Stillwell, Harry C., 51 W. Milton av., Rahway
Strauss, Clifton J., 911 Springfield av., N. Providence
Strelinger, Alexander, 689 Newark av., Elizabeth
Strom, Abraham, 410 W. 7th st., Plainfield
Tator, Arthur E., 57 De Forest av., Summit
Terrell, Edward E., 110 Alden st., Cranford
Tidaback, John D., 447 Springfield av., Summit
Townsend, L. M., 37 Grant av., E., Roselle Park
Turner, Wm. F., 519 Magie av., Elizabeth
Tyndall, Alice E., 329 Mountain av., Westfield
Tyndall, Martha W., 329 Mountain av., Westfield
Van Horn, Alfred F., 514 Central av., Plainfield
Vinciguerra, Michael, 604 Westminster av., Elizabeth
Vitale, Dominic V., 681 Newark av., Elizabeth
Vogel, Herbert A., 1060 E. Jersey st., Elizabeth
Wade, Simon F., 555 Newark av., Elizabeth
Wacker, Wm. F., Jr., 1224 Salem av., Hillside
Wagner, Otto, 111 Stiles st., Elizabeth
Wagner, Richard, 43 S. Broad st., Elizabeth
Walsh, Ronald J., 118 E. 5th av., Roselle
Walsh, Thomas J., Jr., 355 S. Broad st., Elizabeth
Ward, Leo J., 137 W. Jersey st., Elizabeth
Waincke, Frank H., 523 Westfield av., Elizabeth
Wegryn, Louis S., 254 First av., Elizabeth
Weigel, Edgar W., 970 Park av., Elizabeth
Weigel, Elmer P., 727 Watchung av., Plainfield

Weissman, M. T., 727 Wood av., Linden
Western, Frederic B., 1227 Morris av., Townley
Whitken, Albert I., 1056 North av., Elizabeth
Williams, Frank A., 324 W. Jersey st., Elizabeth
Williams, Leonard D., 518 Park av., Plainfield
Wolgin, Philip A., 445 Elmora av., Elizabeth
Wood, Chas. F., P. O. Box 195, Westfield
Woody, McIver, 454 Union av., Elizabeth
Yood, Raphael, 401 Grant av., Plainfield
Yorke, Edward T., 516 N. Wood av., Linden
Young, Franklin C., 120 Summit av., Summit
Yuckman, Robert O., 224 W. Jersey st., Elizabeth
Yuckman, Wm., 224 W. Jersey st., Elizabeth
Zeitlin, Herman H., 943 N. Wood av., Linden

Honorary Members

Ard, Frank C., Plainfield
Harrison, Jos. B., 302 E. Broad st., Westfield

Resigned

Orgar, P. B.
Ferguson, Chas.
Page, Robt. O.

Transfers to

Conway, Jas. V.
Holt, Evelyn
Ford, Theodore R.

Transfers from

Goodrich, Stewart L.
Radding, Moses B.
Strickland, Geo.
White, Harry J.

Number of active members and basis of representation, 291, Feb. 5, 1937.

100 per cent paid up, Feb. 5, 1937.

WARREN COUNTY (21)

Society organized February 15, 1826. Meets on the third Tuesday of January, April, July and October; the last named being the Annual Meeting.

President, Varney, Wm., Washington

Vice-President, Weres, James, Alpha

Treasurer, Cummins, G. W., Belvidere

Reporter, Bossard, H. B., Phillipsburg, R. D. No. 2

Censors, Bossard, H. B., Phillipsburg
Curtis, F. W., Stewartville
Lyon, C. H., Phillipsburg
Cummins, G. W., Belvidere
Baldorf, Herman, Belvidere

Active Members

Albertson, Wm. C., Belvidere
Baldauf, Herman, Jr., Front st., Belvidere
Bloom, Lawrence H., 8 Market st., Phillipsburg
Bossard, Harry B., R. D. No. 2, Phillipsburg
Bostwick, Wallace, Blairstown
Brasefield, Edgar N., 218 Chamber st., Phillipsburg
Buchanan, Ralph McK., 131 So. Main st., Phillipsb'g
Cummins, Geo. W., 202 Mansfield st., Belvidere
Curtis, Frank W., Stewartsville
Drake, Paul F., 85 Summit av., Phillipsburg
Hackett, Leon W., 173 Belvidere av., Washington
Harmon, Walter H., Hackettstown
*Hoagland, L. B., Oxford
Jackson, D. P., 420 Front st., Belvidere
Krausz, Emery, 577 S. Main st., Phillipsburg
La Riew. Fredk. J., 107 E. W'h'gt'n av., W'h'gt'n
Lemmon, Junius, 26 W. Washington av., Wash'gt'n
Lyon, Chas. H., 79 Lewis st., Phillipsburg
Marlett, Neumann C., 311 Front st., Belvidere
Pursell, Wm. D., 508 S. Main st., Phillipsburg
Shimer, Floyd A., 88 Lewis st., Phillipsburg
Skinner, Wm. F., Washington
Spillane, Timothy H., 379 S. Main st., Phillipsburg
Stone, Russell B., Phillipsburg
Vail, Wm. P., Blairstown
Varney, Wm. H., 120 Belvidere av., Washington
Weres, James, Boulevard N., Alpha
West, Guernsey F., 109 S. Main st., Phillipsburg
Wing, Raymond, Blair Hill, Blairstown
Wolf, Frank A., 494 S. Main st., Phillipsburg
Zuck, Arthur C., 22 Broad st., Washington

Number of active members and basis of representation, 30, Feb. 5, 1937.

SUMMARY

Active Members

ATLANTIC	115
BERGEN	222
BURLINGTON	55
CAMDEN	174
CAPE MAY	23
CUMBERLAND	55
ESSEX	788
GLOUCESTER	39
HUDSON	395
HUNTERDON	21
MERCER	201
MIDDLESEX	113
MONMOUTH	122
MORRIS	88
OCEAN	25
PASSAIC	273
SALEM	20
SOMERSET	55
SUSSEX	20
UNION	291
WARREN	30
	3225

The State Society carries no delinquent members. Those County Societies reporting as many members as were paid up last year are carried in this 100 per cent paid up column:

Atlantic
Bergen
Camden
Cape May
Essex
Gloucester
Hudson
Mercer
Monmouth
Morris
Ocean
Passaic
Salem
Somerset
Sussex
Union

Associate Members

There are only seven County Societies who elect Associate Members:

BERGEN	17
ESSEX	84
HUDSON	15
MERCER	23
MIDDLESEX	9
OCEAN	1
PASSAIC	1
	150

Number of members on the Official List, Feb. 5th, 1936:	
Active	2840
Associate	114
Total	3084

Number of members on the Official List, Feb. 5th, 1937:	
Active	3225
Associate	150
Total, on date of April 15th, 1937	3375

A gain of 385 members.

Deaths occurring during the past year 79

Respectfully submitted,

J. B. Morrison, M.D.,

Secretary.

MEETINGS OF THE COUNTY SOCIETIES

Atlantic County.—Meets second Friday evening monthly, except in June, July, August and September. Annual Meeting in May.

Bergen County.—Meets on second Tuesday each month except July and August. Annual Meeting in May.

Burlington County.—Meets second Thursday evening of each month except June, July and August. Annual Meeting in November.

Camden County.—Meets first Tuesday in each month, October to May inclusive, with an outing in June. Annual Meeting in May.

Cape May County.—Four regular meetings each year. Meets on first Tuesday in April and October. Annual Meeting in November. Semi-annual meeting in April. Other two meetings at call of the President.

Cumberland County.—Meets on the second Tuesday in October, December, February, April and June. Annual Meeting in April.

Essex County.—Annual Meeting is the second Thursday in May. Other meetings on the second Thursday of each month, October to May, inclusive.

Gloucester County.—Regular meetings on the third Thursday of each month except June, July and August. Annual Meeting in May. Annual Social Session in October.

Hudson County.—Meets first Tuesday evening of each month, October to May, inclusive. If a legal holiday, the meeting is held on the next day. Annual Meeting in May.

Hunterdon County.—Meets on the fourth Tuesday of January, April, July and October, April being the Annual Meeting.

Mercer County.—Meets on the second Wednesday of each month, except July, August and September, at 8:30 p. m., in the Trenton Country Club. Annual Meeting in December. Annual Banquet second Wednesday in November.

Middlesex County.—Meets on third Wednesday of each month, September to June inclusive. Annual Meeting in December.

Monmouth County.—Meets on the fourth Wednesday in each month from October to June, inclusive. Annual Meeting on 4th Wednesday in April.

Morris County.—Meets on the third Thursday in each month from October to June, inclusive. Annual Meeting in June.

Ocean County.—Meets second Wednesday each month except June, July, August and September. Annual Meeting in November.

Passaic County.—Meets on the second Thursday evening of each month, except June, July and August. Annual Meeting in October.

Salem County.—Meets on the second Friday in February, April, October and December. Annual Meeting in April. Social Meeting in May.

Somerset County.—Meets on the second Thursday evening in February, April, June, October and December. Annual Meeting in June.

Sussex County.—Annual Meeting on the second Tuesday in May; other meetings bi-monthly, September to May inclusive, at call of President.

Union County.—Meets second Wednesday of February, April, October and December. Annual Meeting in October.

Warren County.—Meets on third Tuesday of January, April, July and October, the last named being the Annual Meeting.

An Alphabetical List of the Members of the Medical Society of New Jersey

Compiled March 1937

The figures in parenthesis refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

*Deceased.

ACTIVE MEMBERS

Abbate, Chas. C., 32 Main st., Lodi (2)
Abel, Arthur R., 144 Harrison st., East Orange (7)
Abel, Henri E., 339 Union av., Elizabeth (20)
Abell, Elvira D., Sand Spring rd., Morristown (14)
Abey, W. J. H., 23 N. Delaware av., Pennington (11)
Abrams, Abram B., 668 Clinton av., Newark (7)
Ackerman, Arthur F., 129 Summit av., Summit (20)
Ackermann, Edward, 5 Richards av., Dover (14)
*Ackerman, James, Asbury Park (13)
Ackley, David B., 21 N. Clinton av., Trenton (11)
*Adams, Chas. F., 34 W. State st., Trenton (11)
Adams, G. B., McC., 304 Monmouth st., Glouc'r C. (4)
*Adams, John K., 3 Prospect st., East Orange (7)
Adams, Rayford K., Skillman (18)
Adams, Samuel, 29 Highland av., Jersey City (9)
Adelman, Benjamin B., 190 Clinton av., Newark (7)
Africano, J. V., 4246 Hudson blvd., Union City (9)
Agnew, Hobart M., 27 S. Fullerton av., Montc'r (7)
Agolia, M. W., 1347 Blvd., West New York (9)
Aikman, E. M., 30 Oak Lane, Essex Fells (7)
Ainsley, H. Bryson, 246 Union st., Jersey City (9)
Albano, Joseph, 535 N. 7th st., Newark (7)
Albertson, W. C., Belvidere (21)
Albrecht, Wm. J., 25 N. Bridge st., Somerville (18)
Albright, L. F., 118 Madison av., Spring Lake (13)
Alexander, Hugo, 928 Hudson st., Hoboken (9)
Alexander, Samuel, Main st., Park Ridge (2)
Alexander, Walter G., 48 Webster pl., Orange (7)
Alford, Ralph I., 83 Park st., Montclair (7)
Allan, James S., 144 Harrison st., East Orange (7)
Allen, Arthur A., 365 Park av., Paterson (16)
Allen, G. Herbert, 181 Roseville av., Newark (7)
Allen, Isaac L., 521 Palisade av., Union City (9)
Allen, James M., 657 Main av., Passaic (16)
Allen, Raymond N., 144 Harrison st., E. Orange (7)
Alling, Frederic A., 15 Washington st., Newark (7)
Allman, David B., 104 St. Charles pl., Atl. City (1)
Alpert, Edward, 661 Jersey av., Jersey City (9)
Alter, Nicholas M., 410 Fairmount av., Jer. City (9)
Altman, Charles D., 301 Highland av., Newark (7)
Altschul, Frank J., 177 Garfield av., L. Branch (13)
Ambrose, Anthony, 71 Congress st., Newark (7)
Amdur, L. A., 834 Westside av., Jersey City (9)
*Anderson, John E., Neshanic (18)
Anderson, J. F., 195 College av., New Brunsw'k (12)
Anderson, Reuben M., 408 Main st., Hackensack (2)
Anderson, Richard D., 465 High st., Burlington (3)
Anderson, W. M., 20 Kings hwy., W., Haddonfield (4)
Andrews, C. L., 1616 Pacific av., Atlantic City (1)
Andrus, David L., 805 Cooper st., Camden (4)
Angelillis, P., 76 State st., Hackensack (2)
Angelo, J. A., 1190 Paterson Plank rd., Secaucus (9)
Anthony, D. W., 201 Witherspoon st., Princeton (11)
Antonius, N. A., 27 W. Market st., Newark (7)
Antopol, Wm. A., 201 Lyons av., Newark (7)
Anuario, Chas. B., 283 S. Centre st., Orange (7)
Apgar, Francis A., 68 Main st., Oldwick (10)
Applebaum, Irving L., 152 Clinton av., Newark (7)
Applegate, E. T. R., 1125 Greenw'd av., Trenton (11)
Applestein, Robert, 569 E. State st., Trenton (11)
Appold, G. D., 60 E. Church st., Bergenfield (2)
Areson, W. H., 153 Bellevue av., Up. Montclair (7)
Aria, Michael H., 31 Glenwood av., Jersey City (9)
Arlitz, Wm. J., 107 Newark st., Hoboken (9)
Armstrong, L. B., 121 S. Euclid av., Westfield (20)
Armstrong, R. R., 114 Pennington av., Passaic (16)
Arndt, Frank R., 217 29th st., Woodcliff (9)
Aronis, Harry R., 239 E. Hanover st., Trenton (11)
Arthur, Frances H., 138 Westfield av., Elizab'th (20)
Ash, Arthur F., 710 Boulevard E., Weehawken (9)
Ash, Frank W., 180 Carroll st., Paterson (16)
Ash, Samuel, 25 Johnson av., Newark (7)
*Ashcraft, Samuel, Mullica Hill (8)
Asher, Maurice, 186 Clinton av., Newark (7)
Ashley, Harmon H., 190 W. State st., Trenton (11)
Assante, Mario H., Evesham av., Magnolia (4)
Aszody, Paul, 340 Waverly av., Newark (7)
Athey, K. L., 3616 Westfield av., Camden (4)
Atkinson, J. M., Hanover (14)
Atkinson, Jas. W., 603 S. Maple av., Glen Rock (16)
Atwell, David R., 920 Hudson st., Hoboken (9)
Atwood, Edw. Allison, 360 Park av., Paterson (16)
Auriemma, Michele, 419 Adams st., Hoboken (9)
Austin, Thomas R., 16 Alden st., Cranford (20)
Avery, P. S., Middlesex Genl. Hosp., N. Br'nsw'k (12)
Avidan, Maurice S., 30 Stratford pl., Newark (7)
Axford, W. Homer, Chester (9)
Axilrod, M. H., 2620 Pacific av., Atlantic City (1)

ASSOCIATE MEMBERS

Alcamo, J. H., 30 Oak lane, Essex Fells (7)
Allman, S. J., 215 N. Main st., Hightstown (11)
Anderson, Robert C., 196 Smith st., Newark (7)
Atkinson, Jas. Q., 423 E. State st., Trenton (11)

ACTIVE MEMBERS

Babbitt, H. M., Jr., 507 Park av., Plainfield (20)
Bachmann, W., 87 Hillcrest ter., East Orange (7)
Bacon, Mary, 278 E. Commerce st., Bridgeton (6)
Baechler, Jules, 439 16th st., West New York (9)
Baeseman, R. W., 501 Grand av., Asbury Park (13)
Bahnson, Conrad M., 170 Bowers st., Jersey C. (9)
Bailey, Chas. P., 422 First st., Lakewood (13)
Bailey, Wilson G., 512 Broadway, Camden (4)
Bailyn, Emanuel, 331 16th st., W. New York (9)
Baird, Thompson M., 124 Grand pl., Arlington (7)
Baker, A. L., 389 W. Blackwell av., Dover (14)
Baker, Banks S., 601 Walnut st., Camden (4)

Baker, Chas. F., 198 Clinton av., Newark (7)
Baker, Elsworth F., State Hospital, Marlboro (13)
Baker, Hugh W., 8th & Elmer sts., Vineland (6)
Baker, Maclyn, 638 Stuyvesant av., Irvington (7)
Baker, Maurice E., 1149 Kaighn av., Camden (4)
Baker, Philip W., High Bridge (10)
Baker, Raymond D., 52 DeForest av., Summit (20)
Baketel, H. S., 155 Van Wagenen av., Jer. City (2)
Baldauf, Herman, Jr., Front st., Belvidere (21)
Baldwin, John F., 1474 Windsor rd., W. Englew'd (2)
Baldwin, Samuel H., 626 Clinton av., Newark (7)
Ballinger, Reeve L., 759 Kearny av., Arlington (9)
Banach, Leon, 2747 Blvd., Jersey City (9)
Banks, Winifred D., 6 N. Munn av., E. Orange (7)
Barb, Kirk B., 1303 Princess av., Camden (4)
Barbarito, W. N., 135 Bentley av., Jersey City (9)
Barbash, Samuel, 1902 Pacific av., Atlantic City (1)
Barbour, G. E., 118 W. High st., Somerville (18)
Barishaw, S. B., 5 Bentley av., Jersey City (9)
Barkhorn, Chas. W., 223 Roseville av., Newark (7)
Barkhorn, Henry C., 45 Johnson av., Newark (7)
Barlow, Frank A., 967 Madison av., Paterson (16)
Barlow, Geo. B., 63 Spring Lane, Englewood (2)
Barnes, Wm. J., 155 Engle st., Englewood (2)
Barnshaw, Harold D., 2626 Federal st., Camden (4)
Baron, Leo E., 509 No. Wood av., Linden (20)
Barr, Abraham H., 830 Wood av., Linden (20)
Barr, Joseph, 975 Madison av., Paterson (16)
Barrett, Arthur F., 835 Montgomery st., J. City (9)
Barrett, Jos. F., 230 Parker av., Maplewood (7)
Barroso-Bernier, A., 173 Morse pl., Englewood (2)
Barroway, Jas. N., 3064 Federal st., Camden (4)
Barrows, Arthur M., 440 Hamilton av., Trenton (11)
Barrows, Victor I., 316 N. Broadway, Pitman (8)
Barry, Rolla G., 908 W. State st., Trenton (11)
Bartlett, Clara K., 4301 Atlantic av., Atl. City (1)
Baruch, Rudolf J., 414 Elizabeth av., Elizabeth (20)
Basralian, J. B., 238 Boulevard, Hasbrouck Hgts. (2)
Bassett, L. C., 320 New Market rd., Dunellen (12)
Bassett, Norman H., Prof. Arts Bldg., Atl. City (1)
Bauer, Harry W., 515 Maple av., Palmyra (3)
Baum, Felix, 765 S. 10th st., Newark (7)
Baum, Samuel, 10 Osborne ter., Newark (7)
Bauman, Everett O., 17 Hillside av., Newark (7)
Bayne, Jos. K., 12 Princeton av., Princeton (11)
Beairsto, Everett B., 178 W. State st., Trenton (11)
Beaver, Jennie Dean, 44 Elm st., Morristown (14)
Becker, Chas. F., 620 Benson st., Camden (4)
Becker, Fred'k. W., 14 Clinton pl., Newark (7)
Becker, Geo. L., 646 E. 28th st., Paterson (16)
Becker, Sidney D., 140 Maple pl., Keyport (13)
Becket, Geo. C., 350 Springdale av., E. Orange (7)
Beekman, John B., Bedminster (18)
*Beekman, Jesse H., Sayreville (12)
Behrens, Herman H. E., 312 Webster av., J. City (9)
Beideman, C. M., 5 W. Maple av., Merchantville (4)
Beir, Ily R., 114 S. Virginia av., Atlantic City (1)
Beisler, Lawrence G., 1528 N. Broad st., Hillside (20)
Belafsky, H. A., 472 Rahway av., Woodbridge (12)
Belfer, Jacob J., 1235 Chambers st., Trenton (11)
Belford, Ralph J., 90 Nassau st., Princeton (11)
Beling, Christopher A., 111 Clinton av., Newark (7)
Beling, Christopher C., 111 Clinton av., Newark (7)
Bellak, Ellis R., Leesburg (6)
Bellis, Horace D., 437 E. State st., Trenton (11)
Belting, Arthur W., 202 E. Hanover st., Trenton (11)
Ben-Asher, Solomon, 260 Bergen av., Jersey City (9)
Bender, Max, 327 23rd st., Union City (9)
Bender, Theo., 666 Broadway, Paterson (16)
Bendix, Gerhard M., 4 W. Somerset st., Raritan (18)
Benedict, Alfred C., 121 Irvington av., S. Orange (7)
Bengelsdorf, Aron, 29 Clinton pl., Newark (7)
Benjamin, H. C., 59 Crescent av., Jersey City (9)
Benjamin, Jos. F., 203 Godwin av., Ridgewood (16)
Bennett, Samuel D., 118 Pine st., Millville (6)
Bennett, Wm. F., Essex Mt. Sanatorium, Verona (7)
Bensley, Maynard G., 129 Summit av., Summit (20)
Bentley, David F., Jr., 406 Cooper st., Camden (4)
Berenson S. J., 1012 E. Jersey st., Elizabeth (20)
Berg, Samuel, 156 Roseville av., Newark (7)
Berger, Harry, 921 S. Clinton av., Trenton (11)
Berger, Wm. A., 346 Roseville av., Newark (7)
Bergin, Jos. V., 315 Broadway, Paterson (16)
Bergman, Meyer W., 31 Lincoln pk., Newark (7)
Bergsma, Stuart, 257 Paulison av., Passaic (16)
Berk, M. D., 320 Ramapo av., Pompton Lakes (16)
Berke, Raynold N., 430 Union st., Hackensack (2)
Berkhout, P. G., 106 Haledon av., Prospect Pk. (16)
Berkow, Samuel G., 138 Market st., P. Amboy (12)
Berkowitz, Benjamin, 20 Bank st., Bridgeton (6)
Berlin, Jos. I., 9 Gifford av., Jersey City (9)
Berman, H. Robt., 286 Roseville av., Newark (7)
Berman, Jacob J., 409 Market st., Trenton (11)
Berman, Leonard, 155 Summit av., Summit (20)
Bernardini, Oddino, 266 John st., Oradell (2)
Bernhard, Wm. G., 226 N. Grove st., E. Orange (7)
Bernheisel, Louis E., Reading av., Tuckahoe (5)
Berry, Clarence H., 129 Summit av., Summit (20)
Beshlian, Hagop K., 7 Lee pl., Paterson (16)
Betancourt, R. R., 406 Cooper st., Camden (4)
Beveridge, W. W., 1000 Grand av., Asbury Pk. (13)
Beyer, Othmer J., 42 Laurel av., Irvington (7)
Beyer, Wm., 612 Undercliff av., Edgewater (2)
Bianchi, Angelo R., 228 S. 7th st., Newark (7)
Biczak, Arkad K., 27 Monroe st., Passaic (16)
Bien, Frank A., 999 Clinton av., Irvington (7)
Bigelow, Eliz. F., 117 Irvington av., S. Orange (7)
Bigelow, Nelson S., 117 Irvington av., S. Orange (7)
Binder, Joseph, 149 Garfield av., Long Branch (13)
Bingham, A. W., 144 Harrison st., E. Orange (7)
Bird, Frank L., Netcong (14)
Birdsall, Clarence A., 3 Smull av., Caldwell (7)
Birely, Morris F., 104 Avondale rd., Ridgewood (16)
Birrell, R. G., 554 Westminster av., Elizabeth (20)
Bishop, Carl, 831 Madison av., Plainfield (20)
Bissett, John V., 29 Hawthorne av., E. Orange (7)
Bitten, Robt. M., 33 Romaine av., Jersey City (9)
Black, LeRoy W., 3 Addison av., Rutherford (2)
Black, Max, 1192 St. George av., Linden (20)
Blackburne, Geo., 490 Central av., Newark (7)
Blackwell, Enoch, 28 W. State st., Trenton (11)
Blair, Thos. D., 414 Park av., Plainfield (20)
Blaisdell, C. Byron, 489 Broadway, Long Branch (13)
Blampin, Winifred A., Galen Hall, Atl. City (1)
Blanchard, Chas. L., 27 E. Blackwell st., Dover (14)
Blank, Samuel, N. J. Vil. for Epileptics, Skillm'n (18)
Blaugrund, Samuel, 190 W. State st., Trenton (11)
Blaustein, Maurice L., 37 Hillside av., Newark (7)
Blauvelt, Grace B., 123 Prospect st., Ridgewood (2)
Blauvelt, Harold, 46 Parker av., Maplewood (7)
Bleasby, Chas. B., 136 Passaic st., Garfield (2)
Bleick, Theo. E., 61 Van Ness pl., Newark (7)
Bleick, Wm. D., 583 Prospect av., Maplewood (7)
Bleier, Louis, 89 Ferry st., Newark (7)
Blenkle, Victor A., 140 Chadwick rd., Teaneck (2)
Bloch, Harry, 200 E. Jersey st., Elizabeth (20)
Block, Marcus T., 177 Bloomfield av., Newark (7)
Block, Max, 48 N. Fullerton av., Montclair (7)
Bloom, Lawrence H., 8 Market st., Phillipsburg (21)
Blum, Joseph M., 128 Mill st., Trenton (11)
Blumberg, J. 504 Westminster av., Elizabeth (20)
Blythe, R. P., 30 Springfield av., Cranford (20)
Bocchini, Jos., 366 S. 12th st,. Newark (7)
Bohl, Louis J., 329 Broadway, Paterson (16)
Bokor, Emery, 79 Shanley av., Newark (7)
Bonanno, Peter J., 500 35th st., N. Bergen (9)
Bongiorno, Henry D., 516 River st., Paterson (16)
Bono, Jos. J., Paris av., Northvale (2)
Bonynge, H. A., 123 Prospect st., Ridgewood (16)
Bookrajian, Edw. N., 5459 Boulevard, N. Bergen (9)

Booth, Walter S., 318 Grier av., Elizabeth (20)
Booth, Wm. K., 304 William st., Boonton (14)
Boothby, I. R., Clinton (10)
Boozan, W. E., 1139 E. Jersey st., Elizabeth (20)
Bornstein, Paul K., 415 S. Lake dr., Belmar (13)
Borow, Benj., 574 Watchung dr., Bound Brook (18)
Borow, Henry, 507 Church st., Bound Brook (18)
Borow, Louis S., 934 Park st., Bound Brook (18)
Borow, Maurice, 507 Church st., Bound Brook (18)
Borrone, Milton G., 2695 Boulevard, Jersey City (9)
Borshaw, Hyman, 108 Bentley av., Jersey City (9)
Bortone, Frank, 2765 Boulevard, Jersey City (9)
Boselli, Emile H., 614 15th st., Union City (9)
Bossard, Harry B., R. D. No. 2., Phillipsburg (21)
Bossert, Chas. L., 4021 Atlantic av., Atl. City (1)
Bossone, Jos. E., 172 Garfield av., Long Branch (13)
Bostwick, D. S., Cumberland Hotel, Bridgeton (6)
Bostwick, Wallace, Blairstown (21)
Botbyl, Burt W., 927 Madison av., Paterson (16)
Botti, John A., 236 Summit av., Jersey City (9)
Bourns, Edward G., 126 Harrison av., Westfield (20)
Bove, Joseph, 306 Lincoln av., Orange (7)
Bowers, F. Clyde, Prospect st., Mendham (14)
Bowles, Harry H., 36 Woodland av., Summit (20)
Bowyer, F. F., 50 Gifford av., Jersey City (9)
Boyd, John B., 67 E. Front st., Red Bank (13)
Boyer, Chas. G., Annandale (10)
B yes, Jas. G., 744 Watchung av., Plainfield (20)
Boylan, Lawrence B., 630 Main st., Paterson (16)
Boysen, Theo. H., 100 Phila. st., Egg Harbor City (1)
Brackett, Eliz. R., 371 Franklin av., Nutley (7)
Bradford, Stella S., 16 Seymour st., Montclair (7)
Bradshaw, John H., 27 High st., Orange (7)
Brady, Thos. S., 678 Ave. C, Bayonne (9)
Brady, Wm. A., 403 46th st., Union City (9)
Brakeley, Elizabeth, 71 Myrtle av., Montclair (7)
Bramble, H. S., Front & Chestnut sts., Elmer (17)
Brancato, Peter, 17 Church st., Paterson (16)
Brandenberg, L. W., 4260 Boulevard, Union C. (9)
Branin, Howard S., 200 W. Main st., Millville (6)
Branon, Mark E., 76 Ames av., Rutherford (2)
Brasefield, E. N., 218 Chambers st., Phillipsburg (21)
Brauer, Selig L., 234 Bergen av., Jersey City (9)
Braun, Gustav A., 391 Bergen st., Newark (7)
Braun, William, 4307 Maple av., Merchantville (4)
Braunstein, S. C., 424 13th st., W. New York (9)
Braunstein, W. P., 831 Boulev'd E., Weehawken (9)
Bray, Wm. E., 41 Elizabeth st., Pemberton (3)
Breitstadt, C. A., 563 Summer av., Newark (7)
Brennan, A. T. V., Jr., 275 Engle st, Englewood (2)
Brennan, C. L. S., 14 S. Broadway, Gloucester C. (4)
Brennan, John P., 429 Cooper st., Camden (4)
Brennan, Ralph J., 300 Howard av., Radburn (2)
Brennock, T. McG., 3 Webster av., Jersey City (9)
Breslow, A. E., 12 W. Milton av., Rahway (20)
Breslow, Samuel, 157 Market st., P. Amboy (12)
Brevoort, Henry H., 54 Main st., Lodi (16)
Brewer, Wm., 34 Cooper st., Woodbury (8)
Brick, Geo. J., 43 Cottage st., Jersey City (9)
Brien, Wm. M., 449 Main st., Orange (7)
Briggs, Henry, 144 Harrison st., East Orange (7)
Brim, Anne J. S., 74 S. Munn av., East Orange (7)
Brittain, Elmore G., 4 E. High st., Bound Brook (18)
Broadnax, Mary E., 83 Lincoln Park, Newark (7)
Brock, H. F., 417 W. Broad st., Westfield (20)
Brodkin, Eva T., 365 Osborne ter., Newark (7)
Brodkin, Henry A., 365 Osborne ter., Newark (7)
Brody, M. S., 75 Livingston av., N. Brunswick (12)
Brokaw, Chris. A., 1405 North av., Elizabeth (20)
Bromberg, Chas. B., 107 Lexington av., Passaic (16)
Brooke, Chas. R., 1136 S. Broad st., Newark (7)
Brooke, Wm. W., 915 Ave. C, Bayonne (9)
Brooks, Sidney S., 62 12th av., Paterson (16)
Brophy, Francis X., 55 Gifford av., Jersey City (9)
Brotman, Morton M., 90 Avon av., Newark (7)
Brown, Chester R., 22 Midland av., Arlington (7)
Brown, Chester T., Pru. Insurance Co., Newark (7)
Brown, F. L., 67 Livingston av., N. Brunswick (12)
Brown, Harvey S., 5 Club pl., Freehold (13)
Brown, J. C., 101 S. Indiana av., Atlantic City (1)
Brown, John L., 647 Anderson av., Grantwood, (2)
Brown, Kenneth G., 603 Asbury av., Asbury Pk.(13)
Brown, L. Greeley, 173 Madison av., Elizabeth (20)
Brown, Lewis W., 160 Roseville av., Newark (7)
Brown, R. J., 105 Ridgewood rd., S. Orange (7)
Brown, Stanley L., Glen av., Laurel Springs (4)
Brown, Wm. H., 29 Third st., Elizabeth (20)
Browning, W. K., 120 N. Centre st., Merch'tv'le (4)
Browning, W. J., 134 N. Centre st., Merch'tv'le (4)
Brozdowski, John J., 554½ Jersey av., Jer. City (9)
Bruder, A. J., 344 Fairmount av., Jersey City (9)
Bruning, R. H., 435 Westminster av., Elizabeth (20)
Buchanan, R. M., 131 S. Main st., Phillipsburg (21)
Buckley, J. L., 666 Franklin av., Nutley (7)
Buckley, Paul J., 159 Palisade av., Bogota (2)
Buckley, R. T. Jr., Peddie School, Hightstown (11)
Buermann, Robert, 206 Madison av., Lakewood (15)
Bugbee, Fredk. C., 132 Sunset av., Verona (7)
Bull, Louis M., 92 Heller Parkway, Newark (7)
Bull, Robt. I., 531 W. Market st., Newark (7)
Bull, Wm. J., 98 Park st., Montclair (7)
Bullwinkel, F., Ocean B. & 4th av., Atl. Highl'ds (13)
*Bunn, Frank C., 30 Hillyer st., Orange (7)
Bunnell, Fredk. N., Barnegat (15)
Bunting, P. DuB., 712 N. Broad st., Elizabeth (20)
Burke, Stephen E., 212 First av., Newark (7)
Burkett, John P., 43 Curtis av., Woodbury (8)
Burkett, Wendell J., 16 W. Holly av., Pitman (8)
Burn, Victor C., Newton (19)
Burne, John J., 17 Gould av., Newark (7)
Burnett, Chas. B., 109 Main st., South River (12)
Burnham, Lyman, 229 Engle st., Englewood (2)
Burns, Edward L., 269 Broad st., Newark (7)
Burns, G. C. H., County rd. & So. st., Demarest (2)
Burns, W. F., 267 White Horse Pike, Audubon (4)
Burritt, Norman W., 30 Beechwood rd., Summit (20)
Burroughs, E. W., 701 W. State st., Trenton (11)
Busansky, Samuel T., Circle dr., Browns Mills (3)
Busch, Herman, 38 Johnson av., Newark (7)
Bush, Archer C., 40 Union st., Montclair (7)
Bush, Ralph K., 131 E. Park av., Merchantville (4)
Busicco, Philip S., 131 Liberty rd., Englewood (2)
Butcher, Chas., Heislerville (6)
Butenas, Jos. J., 300 First av., Elizabeth (20)
Butler, Eustace C., 249 Bloomfield av., Caldwell (7)
Butler, Vincent P., 33 Bentley av., Jersey City (9)
Butterfield, Arey A., 657 Main av., Passaic (16)
Buvinger, C. W., 50 Washington st., E. Orange (7)
Buzby, B. Franklin, 414 Cooper st., Camden (4)
Byck, Louis, 114 Lyons av., Newark (7)
Byer, M. Yale, 827 E. State st., Trenton (11)
Byers, Clarence W., 176 Union av., Rutherford (2)
Byrne, Jas. A., 181 South st., Morristown (14)

ASSOCIATE MEMBERS

Baiocchi, Pascal, 203 Hunterdon st., Newark (7)
Barnard, F. G., 22 Plymouth st., Montclair (7)
Bergmeyer, Josef T., 422 20th st., W. New York (9)
Biunno, Anthony J., 53 Finlay pl., Newark (7)
Borrella, Dominic D., 476 Hamilton av., Trenton (11)
Borsher, Irving P., 255 Broad st., Bloomfield (7)
Buckley, Richard F., 1106 Bloomfield av., Bl'mf'd(7)
Burbidge, J. R., McCosh Inf., Pr. U., Princeton (11)
Burton-Opitz, Russell, 218 Bridle way, Palisade (2)

ACTIVE MEMBERS

Caggiano, Anthony P., 137 Grove st., Montclair (7)
Cahill, Laurence A., 361 Lafayette st., Newark (7)

Calabrese, D. J., 139 Rochelle av., Rochelle Pk. (2)
Caldroney, T. L., 66 Bergen av., Ridgefield Pk. (2)
Caldwell, J. A., 45 S. Mountain av., Montclair (7)
Callahan, Edward J., 124 St. Paul st., Westfield (20)
Callery, Wm. T., 10 Columbia ter., Weehawken (9)
Calvert, Wm. C., 210 Central av., Orange (7)
Calvin, Chas. H., 80 Commerce st., P. Amboy (12)
Camche, Leon J., 250 Renner av., Newark (7)
Cameron, E. A., 186 S. Burnet st., E. Orange (7)
*Campbell, Duncan, Woodbury (8)
*Campbell, H. B., 21 Court st., Newark (7)
Campbell, J. M., 105 S. Central av., Ramsey (2)
Campbell, Wm., 144 Harrison st., East Orange (7)
Campbell, Wm. K., 96 Third av., Long Branch (13)
Campo, A. Guy, Westville (8)
Candio, Vincent P., 347 Ridge rd., Lyndhurst (2)
Cannon, E. A., 5360 Hudson Blvd., N. Bergen (9)
Canright, Cyril M., 2 Berkley pl., Cranford (20)
Cantini, Raphael S., 147 E. 7th st., Plainfield (20)
Cantrell, Wm. C., 140 Washington av., Clifton (16)
Carabelli, A. Albert, 306 Hamilton av., Trenton (11)
Carberry, Edw. T., 67 S. Main st., Wharton (14)
Carbone, Francesco, 157 Hunterdon st., Newark (7)
Card, Chas. F., 100 W. Milton av., Rahway (20)
Cardwell, Edgar P., 47 Central av., Newark (7)
Carey, David S., 11 E. Main st., Freehold (13)
Caridi, S., 465 Bergenline av., West New York (9)
Carlander, O. R., 1972 Browning rd., Merchantv'le (4)
Carlisle, Jas. M., Merck & Co., Rahway (20)
Carlisle, John H., 129 Prospect st., Passaic (16)
Carlough, D. J., 426 Ellison st., Paterson (16)
Carlucci, Angelo M., 83 Elizabeth av., Caldwell (7)
Carman, Fletcher F., 31 Lincoln Park, Newark (7)
Carmona, Luis R., 141 Wood st., Tuckerton (15)
Carpenter, Cedric C., 129 Summit av., Summit (20)
Carpenter, Wm. H., 39 Aberdeen pl., Woodbury (8)
Carr, Mary B., 1 Astor pl., Jersey City (9)
Carrigan, Francis P., 228 Franklin av., Nutley (7)
Carrington, W. J., 905 Pacific av., Atlantic City (1)
Carroll, C. Walter, 117 Centre st., Trenton (11)
Carroll, Thos. R., 755 Anderson av., Grantwood (2)
Carroll, Wm. V., 211 Academy st., Trenton (11)
Carter, J. F. S., 142 Atkins av., Asbury Park (13)
Cartnick, L. C., 196 Hackensack st., Woodridge (2)
Casale, John B., 359 Bloomfield av., Newark (7)
Casilli, Arturo R., 618 Newark av., Elizabeth (20)
Casselman, A. J., 301 N. Second st., Camden (4)
Cassidy, Samuel H., 50 Osborn st., Keyport (13)
Catanzaro, Francesco, 151 Jefferson st., Passaic (16)
Cater, D. A., 57 S. Harrison st., East Orange (7)
Cella, Chas. F., 335 Hamilton av., Trenton (11)
Cestone, Canio, 521 Pompton av., Cedar Grove (7)
Chaiken, Louis H., 1024 E. Jersey st., Elizabeth (9)
Chalfant, W. P., Jr., 7003 Ventnor av., Ventnor (1)
Chamberlain, Aims R., 30 Lenox pl., Maplewood (7)
Champlin, P. M., 43 S. Arlington av., E. Orange (7)
*Chapman, A. L., Rahway (20)
Chapman, E. J., 203 Danforth av., Jersey City (9)
Chapman, Otis P., 125 Broad st., Elizabeth (20)
Chapman, Robt. W., 835 Bergen st., Newark (7)
Chapnick, M. M., 117 Paterson st., Paterson (16)
Charlton, C. C., 124 S. Illinois av., Atlantic City (1)
Chase, Kalman, 591 N. Maple av., Hohokus (2)
Chase, Wm. E., 585 Main st., Passaic (16)
Chattin, J. Franklin, 671 Broad st., Newark (7)
Chayes, Sydney, 980 Ave. C, Bayonne (9)
Cherashore, Harry N., 363 Centre st., Nutley (7)
Chesner, Wm. A., 1111 Hamilton av., Trenton (11)
Chester, Saul W., 634 Broadway, Paterson (16)
Chew, Elisha C., 603 Pacific av., Atlantic City (1)
Chianese, C. Chester, 464 Hamilton av., Trenton (11)
Chiger, Alex S., 621 High st., Newark (7)
Childers, Robt. J., 604 Park ave., Plainfield (20)
Chisholm, Gibbs, 14 Boston st., Newark (7)
Chmelnik, Abraham G., 299 Clinton av., Newark (7)
Chrisman, Irving, 408 Ellison st., Paterson (16)
Christensen, Alex. H., Lebanon (10)
Christian, H. A., 111 Fairview av., Jersey City (9)
Church, Franklin H., 86 W. Broadway, Salem (17)
Ciccone, A. C., 389 Grand st., Paterson (16)
Ciliberti, F. J., Jr., 5th & Pine sts., Camden (4)
Clarie, D'Arcy C., 526 Broad av., Ridgefield (2)
Clark, C. C., 461 New York av., Union City (9)
Clark, Ernest W., 209 Haddon av., Westmont (4)
Clark, Frank G., White House Station (10)
Clark, John C., 404 Asbury av., Asbury Park (13)
Clark, S. W., 152 S. North Carolina av., Atl. City (1)
Clarke, E. W., 435 Warwick av., W. Englewood (2)
Clarke, Francis M., 116 New st., N. Brunswick (12)
Clarken, Jos. A., 43 Lincoln Park, Newark (7)
Claus, C. H., 776 S. 19th st., Newark (7)
Clay, Arthur T., 351 Totowa av., Paterson (16)
Clayton, Jas. O., 516 Broad st., Newark (7)
Clayton, John C., 73 W. Main st., Freehold (13)
Cleary, Jos. P., Minotola (1)
Clement, Baxter L., 31 Lincoln Pk., Newark (7)
Clement, John B., 209 Warren st., Beverly (3)
Clement, L. B., 124 Kings H'w'y W., Haddonfield(4)
Clippinger, R. D., 220 S. West av., Vineland (6)
Clock, Ralph O., 433 E. 51st st., New York City (2)
Closson, Edward W., Lambertville (10)
Cloud, Albert W., 109 E. Palisade av., Englewod (2)
Cobham, Jas. L., 78 Brinkerhoff st., Jer. City (9)
Coburn, J. W,. 111 N. Oraton Pkwy., E. Orange (7)
Cochrane, Cleland D., Main st., Closter (2)
Coe, Richard, 156 Clinton av., Newark (7)
Coffin, Henry F., 433 Mt. Prospect av., Newark (7)
Cogan, Henry, 128 Carroll st., Paterson (16)
Coghlan, Jasper, 17 Academy st., Newark (7)
Cohen, Chas. C., 217 W. Hanover st., Trenton (11)
Cohen, Herman, 489 Jersey av., Jersey City (9)
Cohen, Herman, 1301 Hamilton av., Trenton (11)
Cohen, Herman N., 714 Park av., Hoboken (9)
Cohen, I. Elvin, 561 Elizabeth av., Newark (7)
Cohen, Julian, 475 Park av., Paterson (16)
Cohen, Maurice, 106 Valley rd., Montclair (7)
Cohen, M. Marvin, 137 Graham av., Paterson (16)
Cohen, Max, 9 Franklin pl., N. Arlington (7)
Cohen, Meyer J., 118 Johnson av., Newark (7)
Cohen, Nathan B., 232 State st., P. Amboy (12)
Cohen, Samuel A., 112 Mercer st., Jersey City (9)
Cohen, Sidney L., 20 Avon av., Newark (7)
Cohen, Sidney P., 512 Franklin av., Nutley (7)
Cohen, Wm., 1007 Greenwood av., Trenton (11)
Cohn, Geo. M., 748 S. 10th st., Newark (7)
Cohn, Hermann, 393 Clinton av., Newark (7)
Cohn, Royal M., 740 Clinton av., Newark (7)
Colby, M. X., 287 Westwood av., L. Branch (13)
Cole, Blase, Newton (19)
Cole, Lewis F., 242 Broadway, Passaic (16)
Cole, W. H., Jr., 116 Chilton st., Elizabeth (20)
Coleman, A. H., Clinton (10)
Coleman, Jos. G., Hamburg (19)
Collier, Martin H., 618 Benson st., Camden (4)
Collier, Wm. S., 1000 S. Broad st., Trenton (11)
Collins, Henry J., 1160 Hamilton av., Trenton (11)
Collins, Jas. J., 116 Main st., Woodbridge (12)
Collins, Laurence M., Greystone Park (14)
Colsh, LeRoy L., 612 Ridgewood rd., Maplewood (7)
Colton, Ethan T., Jr., 31 Park st., Montclair (7)
Comando, Harry N., 690 Clinton av., Newark (7)
Comeau, G. W., 415 Speedwell av., Mor. Plains (14)
Comfort, John B., 50 S. Clinton av., Trenton (11)
Comora, Herman C., 317 16th st., W. New York (9)
Comunale, A. R., 1709 Irving st., Rahway (20)
Conaway, Walt P., 1723 Pacific av., Atlantic City (1)
Condon, John F., 686 Mt. Prospect av., Newark (7)
Conlon, Philip, 25 James st., Newark (7)
Connamacher, H. S., 671 Springfield av., Newark (7)
Connell, Emmet J., 2227 Boulevard, Jersey City (9)

Connell, John, 977 Summit av., Jersey City (9)
Connell, John N., 26 Carlton av., Jersey City (9)
Connelly, John A., 212 W. State st., Trenton (11)
Connolly, John J., 212 W. Market st., Newark (7)
Connolly, Jos. P., 64 Hamilton st., Paterson (16)
Connolly, Richard N., 117 5th st., Newark (7)
Connolly, T. Vincent, 56 Hamilton st., Paterson (16)
Connor, Clarence A., 1586 Center av., Fort Lee (2)
*Conoly, Lacy N., 601 Walnut st., Camden (4)
Conover, E. E., 267 Madison av., Hasbrouck Hgts.(2)
*Conrad, E. K., Hackensack (2)
Conroy, John S., 122 E. Broad st., Burlington (3)
Conty, Anthony J., 318 48th st., Union City (9)
Conway, Jas. V., 673 Jefferson av., Elizabeth (20)
Cook, Hugh F., 21 Roseville av., Newark (7)
Cooke, Wm. H., 303 Main st., East Orange (7)
Cooley, R. L., Dunellen (18)
Cooper, Howard M., 37 Ridge rd., Rutherford (2)
Cooper, I. J., 116 Liv'ngst'n av., New Brunsw'k (12)
Cooper, J. Howard, East Millstone (18)
Cooperman, Wm., 647 Market st., Newark (7)
Copleman, H, B., 50 Livingston av., N. Br'sw'k (12)
Coppola, Edward A., 447 Lexington av., Clifton (16)
Coppoletta, J. M., 452 Palisade av., Clifton Pk. (2)
Corbusier, H. D., 614 Park av., Plainfield (20)
Cordasco, Peter, 526 Broad st., Bloomfield (7)
Corio, Geo. A., 307 S. Clinton av., Trenton (11)
Corn, David, 119 Park st., Ridgefield Park (2)
Cornwell, A. W., 265 N. Laurel st., Bridgeton (6)
Corpening, Flave H., Park av., Laurel Springs (4)
Corrigan, P. H., 1720 S. Broad st., Trenton (11)
Corson, Allen, 824 Wesley av., Ocean City (5)
Corson, Elton S., 133 E. Commerce st., Bridgeton (6)
Corson, Filbert R., 101 S. Indiana av., Atl. City (1)
Corson, Kenneth E., 25 S. Myrtle st., Vineland (6)
Cortese, Alvin E., 26 Ward st., Paterson (16)
*Corwin, Theo. W., Newark (7)
Cosgrove, Samuel A., 254 Union st., Jersey City (9)
Costabile, Vincenzo, 150 Ridge rd., Lyndhurst (2)
Costello, Wm. F., 55 W. Blackwell st., Dover (14)
Cotton, Norman T., 219 Graham av., Paterson (16)
Cottone, Rosario J., 683 Princeton av., Trenton (11)
Cottrell, Judson G., 159 Market st., P. Amboy (12)
Coughlan, Ella A., 10 Oakwood av., Orange (7)
Coughlin, Frank J., 24 Beech st., Arlington (7)
Coughlin, John, 43 Arlington av., Jersey City (9)
Coultas, Aldo B., Madison (14)
Cowlbeck, Harry D., 224 W. State st., Trenton (11)
Cox, Harold C., 208 Stockton st., Hightstown (11)
Cox, John C., 55 Woodland rd., Maplewood (7)
Cox, Wm. W., 79 S. Fullerton av., Montclair (7)
Coxson, Harold P., Laurel rd., Stratford (4)
Crabtree, Loren H., 142 Bellevue st., Elizabeth (20)
Craig, Henry A., 315 William st., Somerville (18)
Crain, W. E., Mount Ephraim (8)
Crandall, John K., 200 Main st., Fort Lee (2)
Crane, Bernard, 306 Pacific av., Atlantic City (1)
Crane, Chas. G., 78 Farley av., Newark (7)
Crane, Norman T., 147 East 7th st., Plainfield (20)
Crawford, G. U., 28 Carnegia av., East Orange (7)
Crawford, John W., Bedminster (18)
Crecca, Anthony D., 76 Second st., Newark (7)
Crecca, D. Wm., 111 Park av., Newark (7)
Cremens, John F., 144 Carroll st., Paterson (16)
Crist, W. A., 725 Collings av., W. Collingswood (4)
Cronin, Francis J., 730 South st., Elizabeth (20)
Cronk, E. I., 57 Livingston av., N. Brunswick (12)
Cropper, C. W., Clarkt'n C'ntry Club, Nyak, N.Y.(9)
Cropsey, Chas. D., 168 Chestnut st., Rutherford (2)
Crossfield, H. C., 144 Harrison st., E. Orange (7)
Crounse, David R., 84 Broadway, Passaic (16)
Crowe, Aldrich C., 735 Atl. av., Ocean City (5)
Crowley, Jos. W., 4005 Westfield av., Camden (4)
Crowley, Leo F, 148 Belmont av., Jersey City (9)
Cryder, Millard, Cape May Court House (5)
Crystell, Edward H., 4 Hawthorne av., Nutley (7)
Culver, Geo. M., 25 Glenwood av., Jersey City (9)
Culver, S. H., 75 Magnolia av., Jersey City (9)
Cummins, Geo. W., 202 Mansfield st., Belvidere (21)
Cunningham, C., Jr., 7th & Wood sts., Vineland (6)
Cupaiuoli, Richard A., 21 31st st., N. Bergen (9)
Currie, Norman W., 508 Central av., Plainfield (20)
Curry, Marcus A., Greystone Park (14)
Curtis, Donald A., 241 Union st., Hackensack (2)
Curtis, Elbert A., 65 Central av., Newark (7)
Curtis, Frank W., Stewartsville (21)
Curtis, Grant P., 312 36th st., Union City (9)
Curtis, Howard C., 129 Chester av., Moorestown (3)

ASSOCIATE MEMBERS

Calisibetta, C. J., 37 Longfellow av., Newark (7)
Caputo, Daniel W., Pru. Ins. Co., Newark (7)
Carroll, Wilfred, 55 Goodwin av., Newark (7)
Chamberlain, R. R., 30 Lenox pl., Maplewood (7)
Clark, Alice L., 206 W. State st., Trenton (11)
Clark, Chas. E., N. J. State Hosp., Trenton (11)
Coca, Arthur F., 425 Grant av., Oradell (2)
Cohen, Samuel, Jer. City Med. Center, Jer. City (9)
Colonna, P. C., 132 Lydecker st., Englewood (2)
Cornish, C. H., 637 Prospect st., Maplewood (7)

ACTIVE MEMBERS

D'Acierno, P. A., 346 Palisade av., Union City (9)
D'Acunto, P., 141 Mt. Prspect av., Newark (7)
D'Agostin, Henry, 243 Fulton ter., Cliffside (2)
D'Arcy, Walter E., 545 E. State st., Trenton (11)
Dalton, Simon E., 117 S. Illinois av., Atl. City (1)
Daly, Edmund J., 921 Bergen av., Jersey City (9)
Dandois, G. F., 220 E. Wildwood av., Wildwood (5)
Dane, Chas., 61 Scotland rd., South Orange (7)
Dane, John, 61 Scotland rd., South Orange (7)
Danzis, Max, 31 Lincoln Park, Newark (7)
Darby, C. E., Plymouth pl. & Atl. av., Ocean C. (5)
Darlington, Emlen P., New Lisbon (3)
Darnall, Wm. E., 5 S. Morris av., Atlantic City (1)
Daron, Simeon, 31 Lincoln Park, Newark (20)
Davenport, Irwin P., 194 W. State st., Trenton (11)
Davenport, Peter B., 764 S. Orange av., Newark (7)
Davey, Thos. N., 41 West 33rd st., Bayonne (9)
Davidson, Edwin N., 102 East Elm st., Linden (20)
Davidson, H. S., 101 S. Indiana av., Atlantic City (1)
Davidson, Henry A., 31 Lincoln Park, Newark (7)
Davidson, Louis L., 31 Lincoln Park, Newark (7)
Davidson, M. M., 128 Grant av., E., Roselle Pk. (20)
Davies, Geo. A., 53 Front st., Elmer (6)
Davies, Geo. W., 35 Fairview av., Verona (7)
Davis, Albert B., 511 Cooper st., Camden (4)
Davis, E. Vernon, Vincentown (3)
Davis, F. Cleveland, 129 Summit av., Summit (20)
Davis, Harold L., 178 W. State st., Trenton (11)
Davis, Jacob M., 1400 High st., Burlington (3)
Davis, Louis, 825 S. 10th st., Newark (7)
Davis, Stanton H., 212 E. 7th st., Plainfield (20)
Davis, Thos. C., 30 Old Short Hills rd., Millburn (7)
Davis, Wm. C., 109 S. Portland av., Ventnor (1)
Davison, C. Spencer, 7 Chestnut st., Salem (17)
Davison, Royden W., 205 W. State st., Trenton (11)
Davison, Wilbur S., Pittfield st., Pennsville (17)
Dawson, Harry, 618 E. 24th st., Paterson (16)
Day, G. E., Frazer & N. J. avs., Collingswood (4)
Day, Hayward F., 37 Craig pl., N. Plainfield (18)
Day, Samuel T., Port Norris (6)
Day, Willis B., 407 E. 7th st., Plainfield (20)
Dayton, Spencer T., 86 Demarest av., Englewood (2)
DeBell, Peter J., 239 Burgess pl., Passaic (16)
DeBiaso, Cornelius V., 9 W. Park pl., Rutherford (2)
DeCesare, F. J., 500 Walnut st., Roselle Park (20)
Decker, Chas. T., 178 Elm st., Westfield (20)

Decker, Henry B., 527 Penn st., Camden (4)
DeFino, F. J., 463 N. 7th st., Newark (7)
DeFreitas, Clement, 423 W. 4th st., Plainfield (20)
DeFuccio, Chas. P., 47 Glenwood av., Jersey City (9)
DeFusco, G. T., 330 Newark av., Jersey City (9)
Degenhardt, I. H., 51 Livingston av., N. Br'sw'k (12)
deHellebranth, R. T., 104 S.Frankfort av.,Ventnor(1)
Deibert, Irvin E., 618 Benson st., Camden (4)
Deich, Samuel R., 162 Lexington av., Passaic (16)
Deichman, Chas. H., 39 Elm st., Morristown (14)
Deignan, Wm. L., 257 Dodd st., East Orange (7)
Delario, Anthony J., 294 Broadway, Paterson (16)
Del Deo, Nicholas V., 49 State st., Newark (7)
Del Duca, Vincent P., 406 Cooper st., Camden (4)
Del Guercio, Olindo, 365 Bloomfield av,. Newark (7)
Del Mauro, Alphonse, 417 21st av., Paterson (16)
*Demarest, L. M., 226 S. Orange av., S. Orange (7)
De Mattia, Michael, 18 Ward st., Paterson (16)
DeMeritt, Chas. L., 1225 Bloomfield av., Hoboken(9)
Denbo, Elic A., 854 Haddon av., Camden (4)
Denelsbeck, J. Otis, 878 E. State st., Trenton (11)
Denes, Oscar, 402 Centre av., Nutley (7)
Dengler, Henry P., Morris av., Springfield (20)
Dennin, Jos. W., 308 Chestnut st., Roselle (20)
DePalma, Anthony F., 290 Central av., Orange (7)
dePons, Isabel S. C., 501 Grand av., Asbury Pk. (13)
Derivaux, John A., 103 Clinton av., Newark (7)
De Rosa, Armand, 290 Union Blvd., Totowa Bor. (16)
De Rosa, John, 150 Fair st., Paterson (16)
Dershimer, Fredk. W., 546 Bergen av., Jer City (9)
De Santo, A. M., 377 Essex st., Hackensack (2)
Desmet, Victor F., 324 Broadway, Paterson (16)
Deutel, Oscar R., 283 Franklin st., Bloomfield (7)
De Vausney, Winfield S., 50 James st., Newark (7)
De Vincentis, Henry, 285 Henry st., Orange (7)
Devlin, Frank, 617 Broadway, Newark (7)
Dewis, Edwin G., 21 Westra st., Interlaken (13)
De Yoe, Leon E., 602 Broadway, Paterson (16)
Dezer, Chas. N., Jr., 210 Main st., Hackensack (2)
Diamond, David I., Oceanport av., Oceanport (13)
Diamond, Jos. G., 512 W. Front st., Plainfield (20)
Dias, Jos. L., 17 Lombardy st., Newark (7)
Dickson, John D., 202 Larch av., Bogota (2)
Dieffenbach, R. H., 570 Mt. Prospect av., Newark (7)
Dieker, Howard, 78 Main st., South River (12)
DiIelsi, Anthony J., 1013 S. 5th st., Camden (4)
Dilger, Fredk. G., 210 Main st., Hackensack (2)
Dillingham, W. I., 431 15th st., W. New York (9)
Dimun, John T., 960 S. Broad st., Trenton (11)
Dinge, Ferdinand C., 67 S. Munn av., E. Orange (7)
Dingman, Norman M., 330 Broadway, Paterson (16)
Disbrow, G. W., Overlook Hospital, Summit (20)
*Disbrow, Harold, Lakewood (15)
Diskan, S. M., 1904 Pacific av., Atlantic City (1)
Diverty, Henry B., 38 Cooper st., Woodbury (8)
Dodd, Edward L., 157 Forest st., Belleville (7)
Dodd, Wm. E., Ocean st. & Bay av., B'ch Haven (15)
Dodson, Louis W., 592 Jersey av., Jersey City (9)
Dolganos, Moses, 268 Palisade av., Jersey City (9)
Donahue, Wm. J., 71 S. 9th st., Newark (7)
Donnelly, Jos. P., 1 Madison av., Jersey City (9)
Donnelly, Robt. J., 208 W. Market st., Newark (7)
Donnelly, Wm. A., 60 N. Hartford av., Atl. City (1)
Donohoe, Lucius F., 140 W. 8th st., Bayonne (9)
Donovan, Joseph, Greystone Park (14)
Doody, Wm. M., 19 Bentley av., Jersey City (9)
Doran, Ralph J., 200 11th st., Hoboken (9)
Doran, Wm. G., 921 Bergen av., Jersey City (9)
Doranz, Harold K., 491 Center st., Trenton (11)
Doremus, W. E., 375 Mt. Prospect av., Newark (7)
Dorn, Elliott I., 267 Vassar av., Newark (7)
Dougherty, Daniel D., 1006 Garden st., Hoboken (9)
Douglass, Richmond, 155 Engle st., Englewood (2)
Douglass, Wm. C., 15 Olcott av., Bernardsville (14)
Dowd, Ambrose F., 239 Broadway, Newark (7)
Downs, Elwood E., 70 S. Childs st., Woodbury (8)
Downs, L. S., 153 Pershing av., Carteret (12)
Downs, Roscius I., 40 Scott st., Riverside (3)
Draesel, Chas., 5681 Hudson Blvd., N. Bergen (9)
Drake, D. E., Greenwood Lake Rd., Newfoundl'd (16)
Drake, L. B., 47 Main st., Franklin (19)
Drake, Paul F., 85 Summit av., Phillipsburg (21)
Dranow, Paul, 233 Franklin av., Nutley (7)
Dreskin, Jacob L., 172 Lyons av., Newark (7)
Drezner, Henry L., 507 S. Warren st., Trenton (11)
Driscoll, C. D., 6 Wh. Horse Pike, Haddon Hgts. (4)
Drury, Alfred J., 268 E. 3rd av., Roselle (20)
DuBois, Morris G., 769 High st., Newark (7)
duBusc, L. C. V., 399 Westfield av., Elizabeth (20)
Duckett, W. J., 21 Carlton av., Jersey City (9)
Dukes, Howard R., 220 Kearny av., Kearny (9)
Dulin, Everett V., 144 Harrison st., E. Orange (7)
Duncan, Owsley B., 606 E. 26th st., Paterson (16)
Dundon, A. H., 135 Somerset st., Plainfield (18)
Dunn, John S., 75 Market st., Salem (17)
Dunn, Theodore B., 395 Frankin st., Bloomfield (7)
Dunning, Walter L., 533 River st., Paterson (16)
Durant, Harold J., 485 Park av., Paterson (16)
Durham, R. E., 130 S. Illinois av., Atlantic City (1)
Durrah, Fred F., 310 Plainfield av., Plainfield (20)
Dwyer, Henry E., 261 Madison av., Passaic (16)
Dwyer, Wm. A., 99 Park av., Paterson (16)
Dyer, Edward H., 102 S. Victoria av., Ventnor (1)

ASSOCIATE MEMBERS

Danielson, J. J., 977 Bergen T'np'ke, N. Bergen (9)
Davis, John E., Jr., N. J. State Hosp. Trenton (11)
Deitz, Joseph R., 320 Centre st., Trenton (11)
Della Fera, Lucien F., 206 First av., Newark (7)
Dembinski, T. H., 1238 S. Clinton av., Trenton (11)
Denberg, Hyman S., 307 Peshine av., Newark (7)
Denison, Ward C., 123 Prospect st., Ridgewood (2)
De Vivo, John A., 225 Littleton av., Newark (7)
Di Norcia, Joseph, 451 N. 7th st., Newark (7)

ACTIVE MEMBERS

Eagleton, Wells P., 15 Lombardy st., Newark (7)
Earp. Ruth, 15 Olcott av., Bernardsville (14)
Eason, Samuel W., 48 DeForest av., Summit (20)
East, Isaac C., Skillman (18)
Eaton, Arthur T., 201 4th av., Haddon Heights (4)
Ebenfield, Samuel W., 344 High st., Newark (7)
Echikson, Joseph I., 845 S. 12th st., Newark (7)
Eckert, Walter L., 720 Shore rd., Somers Point (1)
Eckert, Wm., 672 Palisade av., Union City (9)
Eckhardt, R. A., 50 Green Village rd., Madison (14)
Eddy, Lester R., Sussex (19)
Edelberg, Sidney S., 18 Hamilton av., B. Brook (18)
Edelen, Jas. J., 280 So. Clinton st., East Orange (7)
Edelson, Samuel, 1141 Corlies ave., Neptune (13)
Edgar, Jos. A., 71 Congress st., Jersey City (9)
Edgar, Malcolm S., 129 Summit av., Summit (20)
Edlkraut, E. C., 129 Highland av., Passaic (16)
Edwards, J. Bennett, 35 Engle st., Englewood (2)
Edwards, Lena F., 358 Pacific av., Jersey City (9)
Ehrenfeld, Edward, 115 Lexington av., Passaic (16)
Ehrenfeld, Irving, 115 Lexington av., Passaic (16)
Ehrlich, Max, 513 Westfield av., Elizabeth (20)
Eigen, Louis A., 511 Valley rd., West Orange (7)
Ein, Wm. B., 31 Lincoln Park, Newark (7)
Eisenberg, David S., 31 Lincoln Park, Newark (7)
Ekings, Frank P., 221 Broadway, Paterson (16)
Elias, Elmer J., 827 S. Broad st., Trenton (11)
Elliott, Frazier J., 10 N. Second st., Hammonton (1)
Ellis, Alexander, 513 Broadway, Camden (4)
Ellis, Arthur J., 282 Broad st., Newark (7)
Ellis, Moury I., 177 S. Clinton st., East Orange (7)
Ellis, Van Mashburn, Princeton (11)

Ellmers, B. J., 230 New Milf'd av., New Milford (2)
Elsasser, T. H., 906 Park av., North Bergen (9)
Elwell, Alfred M., 407 Cooper st., Camden (4)
Ely, Lancelot, 128 W. High st., Somerville (18)
Emerson, Linn, Metropolitan Bldg., Orange (7)
Emmer, S. W., Med. Tower, 31 Linc'n Pk., N'w'k (7)
*Emory, George B., Morristown (14)
Engelhart, F. K., 701 Stuyvesant av., Trenton (11)
Englander, Chas., 41 Hillside av., Newark (7)
English, Jas. R., 51 Cypress st., Newark (7)
English, John T., 681 Stuyvesant av., Irvington (7)
Enright, J. G., 25 Kensington av., Jersey City (9)
Epler, Don A., 45 Hillside av., Newark (7)
Epstein, Harry B., 31 Lincoln Park, Newark (7)
Epstein, Rubie, 606 Perry st., Trenton (11)
Erler, Eugene W., 360 Irving av., S. Orange (7)
Ernest, Richard B., 240 W. State st., Trenton (11)
Ervin, Millard B., 572 Prospect st., Maplewood (7)
Essertier, Edward P., 273 State st., Hackensack (2)
Esty, Geoffrey W., 629 E. Broad st., Westfield (20)
Etheridge, Chas. H., 433 Prospect st., E. Orange (7)
Evans, Chas. H., 144 Harrison st., E. Orange (7)
Evans, David P., 144 Harrison st., E. Orange (7)
Evans, Edgar E., 12 Ziegler ter., Pennsgrove (17)
Evans, J. L., 893 Park av., Woodcliff-on-Hudson (9)
Evans, W. D., 2704 Westfield av., Camden (4)
Ewart, Eli W., 531 E. Broad st., Westfield (20)
Ewens, Arthur E., 3600 Pacific av., Atlantic City (1)
Ewing, Harvey M., 31 Trinity pl., Montclair (7)
Ewing, Leslie H., 10 Broad st., Berlin (4)
Eynon, H. K., 579 Haddon av., Collingswood (4)

ASSOCIATE MEMBERS

Eames, W. N., 1871 Pennington rd., Trenton (11)
Eichler, B. B., 159 Bellevue av., Up. Montclair (7)

ACTIVE MEMBERS

Fabian, Paul L., 520 Princeton av., Trenton (11)
Facciolo, Frank, 562 Boulevard, Bayonne (9)
Fagan, Jas. L., 51 Bayard st., New Brunswick (12)
Fahrenbruch, F. D., 101 Garden st., Mt. Holly (3)
Failing, Brayton E., 31 Lincoln Park, Newark (7)
Failmezger, T. R., 17 Green Village rd., Madison (14)
Fairbanks, Warren H., 27 Broadway, Freehold (13)
Faison, John B., 45 Glenwood av., Jersey City (9)
Falcone, Nicholas A., 27 Duer st., N. Plainfield (18)
Falkinburg, LeRoy W., Forked River (15)
Fanburg, Sol J., 31 Lincoln Park, Newark (7)
Farden, Jos. L., 342 Roseville av., Newark (7)
Farmer, Vincent, 288 State st., Hackensack (2)
Farmer, Walter D., Church st., Allentown (11)
Farr, Irving L., 214 Walnut st., Montclair (7)
Farr, John C., 75 10th st., Hoboken (9)
Farr, Walter J., 288 Griggs av., Teaneck (2)
Farrell, E. A. H., 100 Kings Highw'y, W., H'd'nf'ld (4)
Fasano, Giovanni, 194 S. 7th st., Newark (7)
Fattel, Henry C., 593 36th st., North Bergen (9)
Faughnan, Rose C., 97 High st., Passaic (7)
Faulkingham, R. J., 61 Livingston av., N.B'nsw'k(12)
Featherston, D. F., 506 Fourth av., Asbury Pk. (13)
Fechner, Julius, 362 Clinton av., Newark (7)
Federer, John J., 69 Columbia ter., Weehawken (9)
Fee, Elam K., 36 W. State st., Trenton (11)
Feher, L. A. M., 177 Somerset st., N. Brunswick (12)
Feigenoff, Israel, 420 Broadway, Paterson (16)
Fein, Bernard, 585 Elizabeth av., Newark (7)
Feinberg, David D., 837 Ave. C, Bayonne (9)
Feinberg, H. D., 384 Second av., Long Branch (13)
Feinstein, Louis, 410 Pacific av., Atlantic City (1)
Feleppa, Edward E., 239 Morris av., Summit (20)
Fell, Alton S., 529 E. State st., Trenton (11)
Fellman, Morris, 118 Jewett av., Jersey City (9)
Feman, J. Geo., 141 Main st., Keansburg (13)
Fendrick, Edward, 91 Watson av., East Orange (7)
Feneck, Chas. C., 510 Roma av., Phoenix, Ariz. (7)
Ferenczi, Louis J., 33 Edwards st., Bayonne (9)
Ferguson, Wm. E., 22 James st., Newark (7)
Fermaglich, H. B., 881 Garrison av., Teaneck (2)
Fern, Samuel S., 122 Elizabeth av., Newark (7)
Ferrari, A. F., 110 Hackensack av., E. Rutherf'd (2)
Ferriss, Ruth B., 10 De Hart st., Morristown (14)
Fessler, Albert J., 1544 S. Broad st., Trenton (11)
Fessman, J. W., Jr., Clem'ts B'dge rd.,Runnemede(4)
Fewsmith, Jos. L., 120 Second av., Newark (7)
Fiedler, Michael J., 247 Crawford ter., Union (20)
Field, Frank L., Far Hills (18)
Fifer, Wm. T., 748 Ave. C, Bayonne (9)
Filkins, C. E., 418 White Horse Pike, Audubon (4)
Fine, Hyman P., 151 Market st., Perth Amboy (12)
Fine, Moses J., 65 Girard pl., Newark (7)
Fine, Sydney G., N. J. State Hospital, Trenton (11)
Fineberg, J. C., 50 Glenwood av., Jersey City (9)
Fin gan, Paul J., 200 W. State st., Trenton (11)
Finesilver, Edward M., 53 Lincoln Park, Newark (7)
Finger, Fredk. A., 938 Ave. C, Bayonne (9)
Fink, Irving E., 129 Lyons av., Newark (7)
Finke, Chas. H., Sr., 317 York st., Jersey City (9)
Finke, Geo. W., 237 State st., Hackensack (2)
Finke, John H. D., 19 Hudson st., Hackensack (2)
Finkel, Joshua, 368 Clinton av., Newark (7)
Finkelstein, A. S., 670 Clinton av., Newark (7)
Finkler, Rita S., 35 Leslie st., Newark (7)
Finn, Fredk. A., 921 Bergen av., Jersey City (9)
Finn, H. R. W., 94 Lembeck av., Jersey City (9)
Fiorello, Jos. R., 706 Princeton av., Trenton (11)
Fischman, Harold H., 326 Avon av., Newark (7)
Fish, C. M., 15 W. Washington av., Pleasantville (1)
Fisher, Jas. A., 501 Grand av., Asbury Park (13)
Fisher, Samuel, 808 Madison av., Paterson (16)
Fisher, Stella C., 4405 Westfield av., Camden (4)
Fishkoff, Alex. H., 132 Market st., Perth Amboy (12)
Fisler, Chas. F., 140 Maple st., Clayton (8)
Fitch, Thos. S. P., 916 Park av., Plainfield (20)
Fithian, Geo. W., 266 High st., Perth Amboy (12)
FitzHugh, Wm. F., 65 Bergen av., Ridgefield Pk. (2)
Fitzpatrick, Edw. F., 546 W. Market st., Newark (7)
FitzPatrick, L. J., 134 Bergen av., Ridgefield Pk. (2)
*Flaherty, M. E., 36 Glenwood av., Jersey City (9)
Flanagan, John J., 47 Central av., Newark (7)
Fleming, Chas. L., 42 W. Main st., Pennsgrove (17)
Flichtenfeld, Morris, 283 4th st., Jersey City (9)
Flint, Edgar T., 44 E. Somerset st., Raritan (18)
Flitcroft, Wm., 510 River st., Paterson (16)
Flower, Morris A., 39 Lincoln Park, Newark (7)
Flynn, E. A., 161 Washington av., Belleville (7)
Flynn, Thos. H., 41 High st., Somerville (18)
Fooder, Horace M., 110 Main st., Williamstown (8)
Ford, Theodore R., 144 Harrison st., East Orange (7)
Fordyce, C. P., 921 C st., Lincoln, Nebraska (20)
Forer, Robt., 247 Centre st., Trenton (11)
Forney, Norman N., 44 N. Main st., Milltown (12)
Forsythe, A. E., 44 N. Kentucky av., Atlantic C'y(1)
Forsyth, K. C., 611 Mt. Prospect av., Newark (7)
Fort, J. Irving, 306 Roseville av., Newark (7)
Fort, Wm. B., 147 E. 7th st., Plainfield (20)
Forte, Frank S., 318 Roseville av., Newark (7)
Forte, Fulvio C., 65 Hudson st., Hackensack (2)
Fost, Wm. H., 107 Franklin st., Belleville (7)
Foster, F. L., 320 Springfield av., Cranford (20)
Foster, Herbert W., 2 Erwin Park, Montclair (7)
Foster, Wm. S., 233 Mt. Prospect av., Newark (7)
Fowler, Royale H., 744 Broad st., Newark (7)
Fox, Wm. W., 101 S. Indiana av., Atlantic City (1)
Francis, A. M., 80 West End av., Somerville (18)
Frank, Morris, 920 Ave. C, Bayonne (9)
Frank, Myrtile, 227 Philadelphia st., Egg Harbor (1)
Frank, Nathan, 186 Bowers st., Jersey City (9)
Franklin, I. H., 191 Palisade av., Jersey City (9)

Franklin, Jos. E., 127 Westfield av., Elizabeth (20)
Franklin, Louis, 191 Palisade av., Jersey City (9)
Franklin, Sidney I., 15 Tenafly rd., Englewood (2)
Franzoni, A. E., 938 Brunswick av., Trenton (11)
Frazee, Wm. H., Jr., 412 Main st., Toms River (15)
Freedman, Harold H., 63 W. Main st.,, Freehold (13)
Freeland, Frank, 281 State st., Hackensack (2)
Freeman, Geo. C., 1 Lenox pl., Maplewood (7)
Freeman, R. D., 103 Scotland rd., S. Orange (7)
Freeman, Roy M., 826 N. Wood av., Linden (20)
Freile, Wm., 25 Tonnele av., Jersey City (9)
Freinkel, Jacob, 2 Hillside av., Newark (7)
Friedburg, Geo. H., 1108 Anna st., Elizabeth (20)
Friedland, Arnold J., Woodbine (5)
Friedland, Ida Monosson, Woodbine (5)
Friedman, A. I., 145 Marshall av., Little Ferry (2)
Friedman, Harry, 721 S. 16th st., Newark (7)
Friedman, Hyman, 1096 Sanford av., Irvington (7)
Friedman, M. H., 526 N. Clinton av., Trenton (11)
Friedman, Milton, Beth Israel Hospital, Newark (7)
Friedmann, L. L., 484 Princeton av., Trenton (11)
Frieman, Hyman, 744 Ave. C, Bayonne (9)
Fritts, Lewis C., 62 East High st., Somerville (18)
Froelich, J. C., 74 Ingraham pl., Newark (7)
Frohwein, Ida H., 125 Morristown rd., Elizabeth (20)
Frost, Inglis F., 181 South st., Morristown (14)
Frundt, Oscar C., 92 Bartholdi av., Jersey City (9)
Fuchs, Jacob N., 1267 S. Broad st., Trenton (11)
*Fuerstman, Herman L., 570 High st., Newark (7)
Fuhrmann, Barclay S., 10 Main st., Flemington (10)
Fulper, Theodore B., Hampton (10)
Funk, Joseph, 615 Elizabeth av., Elizabeth (20)
*Funkhouser, Edgar B., State Hospital, Trenton (11)
Furman, Benj. A., 31 Roseville av., Newark (7)
Furst, N. James, 201 Lyons av., Newark (7)

ASSOCIATE MEMBERS

Felitti, Vincent J., 6 31st st., North Bergen (9)
Fenichel, Benjamin, 39 Peck av., Newark (7)
Finkle, Lester J., 225 Perry st., Trenton (11)
Flicker, David J., 342 Kearny av., Kearny (9)
Fluck, David A., 548 W. State st., Trenton (11)
Fratantuno, M. J., 152 W. Market st., Newark (7)
Friedman, Max, 822 Chambers st., Trenton (11)

ACTIVE MEMBERS

Gadomski, C. F., 103 Murray st., Elizabeth (9)
Gairdner, Thos. M., 319 Broad st., Gibbstown (8)
*Galasso, Attilio, 1 Cutler st., Morristown (14)
Gallaway, Geo. E., 163 W. Milton av., Rahway (20)
Gallo, Jas. S., 32 Zabriskie st., Paterson (16)
Gamon, Robt. S., 527 Cooper st., Camden (4)
*Gandy, Charles M., Ocean View (5)
Ganley, Arthur J., 390 Park av., East Orange (7)
Ganot, Frank I., 639 Ridge st., Newark (7)
Gantz, Emma O., 215 N. Grove st., East Orange (7)
Gardam, Jos. W., 16 Longfellow av., Newark (7)
Gardner, Kenneth E., 1 Park pl., Bloomfield (7)
Garfinkel, Abraham, 30 Broad st., Flemington (10)
Garibaldi, L. J., Jr., 1016 Hudson st., Hoboken (9)
Garrett, Harry S., Park av., Park Ridge (2)
Garrison, Walter S., Cedarville (6)
Gauch, Wm., 177 Ellwood av., Newark (7)
Gauzza, V. P., 505 New Brunswick av., Fords (12)
Geary, Daniel J., 40 Maple av., Morristown (14)
Geary, Paul, 923 Park av., Plainfield (20)
Geary, Russell D., Riverside (3)
Gelber, Isaac, 2052 Morris av., Union (20)
Gelber, Louis J., 550 Mt. Prospect av., Newark (7)
Gennell, Ernest, 298 Parker st., Newark (7)
George, Melbourne E. W., 744 Broad st., Newark (7)
Gerard, Patrick D., 364 Roseville av., Newark (7)
Gerendasy, Julius, 956 E. Jersey st., Elizabeth (20)
German, Geo. B., 429 Cooper st., Camden (4)
Gershenfeld, David B., 20 Hillside av., Newark (7)
Gershman, Jos. G., 99 W. Madison av., Dumont (2)
Gesswein, Carl A., 35 Church st., Matawan (13)
Ghee, Euclid P., 115 Clairmont av., Jersey City (9)
Ghee, Peter F., 734 Ocean av., Jersey City (9)
Giacalone, Vincenzo, 649 Landis av., Vineland (6)
Giambra, S. M., 666 Broadway, Paterson (16)
Gibb, Alice S., 339 Union av., Elizabeth (20)
Gibb, W. Blake, 26 Maple av., Morristown (14)
Gidding, Samuel S., 154 E. Spicer av., Wildwood (5)
Gifford, W. Royal, 247 Park av., East Orange (7)
Giglio, A. S. V., 626 Elizabeth av., Elizabeth (20)
Gilady, Raphael, 205 Union st., Hackensack (2)
Gilbertson, R. L., 39 Green Village rd., Madison (14)
Gille, Hugo, 149 Congress st., Jersey City (9)
Gillis, Alfred G., 37 W. High st., Clayton (8)
Gillson, Hugh V., 21 Lee pl., Paterson (16)
Gillson, John T., 170 Broadway, Paterson (16)
Gilman, Chas. M. B., 59 Seeley av., Arlington (7)
Gilpin, Fletcher, 118 North av., W., Cranford (20)
Ginsberg, Geo., 624 Bloomfield st., Hoboken (9)
Ginsburg, Samuel, 227 Paulison av., Passaic (16)
Gittelman, M., 1028 E. Jersey st., Elizabeth (20)
Gittelsohn, I., 896 Kinderkamack rd., River Edge (2)
Gladen, Ralph Geo., New Lisbon (3)
Glaser, Emanuel, 360 Linden av., Elizabeth (20)
Glasgow, Thos. M., 120 Passaic av., Passaic (16)
Glass, Benjamin E., 609 Watchung av., Plainf'ld (20)
Glass, Oscar, 838 S. 12th st., Newark (7)
Glass, Wm. H., 144 Harrison st., East Orange (7)
Glasser, B. F., 316 George st., New Brunswick (12)
Glasston, Hyman M., 628 N. Wood av., Linden (20)
Glazbrook, Francis H., 37 Ogden pl.,Morristown (14)
Glazer, Edward, 501 Grand av., Asbury Park (13)
Gleeson, Wm. J., 37 Monticello av., Jersey City (9)
Glover, L. L., 53 Kings Highway, W., Haddonf'ld (4)
*Gnasso, E. R., Fort Lee (2)
Gochman, H. M., 166 Hamilton av., Paterson (16)
Godfrey, Alan O., 220 Roseville av., Newark (7)
Godlin, David R., 610 36th st., N. Bergen (9)
Goff, Frank J., 62 Maple av., Red Bank (13)
Goffman, Emanuel, 316 Claremont av., Montclair (7)
Goldberg, Benj. M., 1156 E. State st., Trenton (11)
Goldberg, David, 7 Bogert pl., Westwood (2)
Goldberg, H. H., 814 S. 10th st., Newark (7)
Goldberg, Sam'l A., 169 Gregory av., W. Orange (7)
Goldberg, Louis E., 31 Lincoln Park, Newark (7)
Goldberg, S. M., 353 Washington av., Belleville (7)
Golden, Clement H., 347 16th av., Irvington (7)
Golden, Wm. M., 70 Irving st., Rahway (20)
Goldenberg, Raphael R., 575 Broadw'y, Paterson (16)
Goldfarb, Abraham, 52 Chestnut st., Rutherford (2)
Goldfield, Harold, 225 E. Jersey st., Elizabeth (20)
Golding, Harry N., 180 Carroll st., Paterson (16)
Goldmacher, H. B., 555 S. Broad st., Elizabeth (20)
Goldman, Lester M., 896 S. 16th st., Newark (7)
Goldman, Samuel, 7th and State sts., Camden (4)
Goldsmith, Alfred S., 240 29th st., N. Bergen (9)
Goldstein, Abraham, 404 Madison av., Lakewood (15)
Goldstein, H. H., 318 W. Jer. st., Elizabeth (20)
Goldstein, H. Z., 31 Lincoln Park, Newark (7)
Goldstein, Hyman I., 1425 Broadway, Camden (4)
Goldstein, Samuel M., 40 Johnson av., Newark (7)
Goldstein, Wm. H., 632 Belgrove dr., Kearny (7)
Goldstone, Karl H., 16 18th st., West New York (9)
Gonczy, Edward J., 538 Jersey av., Elizabeth (20)
Good, Richard B., 949 Park av., Union City (9)
Goodfellow, G. P., 196 Prospect st., E. Orange (7)
Gorczyca, Albert G., 538 S. Broad st., Elizabeth (20)
Gordon, Abel, 616 Main av., Passaic (16)
Gordon, Abraham J., 273 Roseville av., Newark (7)
Gordon, B. L., 1616 Pacific av., Atlantic City (1)
Gordon, Carl, 1712 Pacific av., Atlantic City (1)
Gordon, Chas. D., Mt. Arlington (14)
Gordon, Clark H., 808 E. State st., Trenton (11)
Gordon, J. Berkeley, N. J. State Hos., Marlboro (13)

Gordon, Osher, 119 Lexington av., Passaic (16)
Gormley, Cyrus M., 6 Roberts st., Butler (16)
Gould, John H., 263 Franklin av., Ridgewood (16)
Grady, Wm. F., 42 N. Fullerton av., Montclair (7)
Graham, Archibald F., 42 Park av., Paterson (16)
Graham, Ernest E., 4273 S. Broad st., Yardville (11)
Graham, Richard B., 575 Belgrove dr., Arlington (7)
Graham, Theodore K., 278 Park av., Paterson (16)
Gramsch, A. L., N. J. Sanatorium, Glen Gardn'r(10)
Granelli, Humbert A., 213 Garden st., Hoboken (9)
Granelli, Michael S., 68 Hudson st., Hoboken (9)
Grant, Wm. F., 309 Roseville av., Newark (7)
Graves, Chas. C., Jr., State Hospital, Marlboro (13)
Gray, Chas. M., 6th and Grape sts., Vineland (6)
Gray, John W., 142 Clinton av., Newark (7)
Gray, Wm. B., 121 Somerset st., N. Plainfield (18)
Green, David W., 69 Market st., Salem (17)
*Green, James S., 463 N. Broad st., Elizabeth (20)
Green, Thos. J., New Egypt (15)
Greenberg, Geo. A., 55 W. Main st., Somerville (18)
Greenberg, Max, 35 Gesner st., Linden (20)
Greenberg, Philip, 1902 Hudson Blvd., Jer. City (9)
Greenberg, Samuel, 46 Johnson av., Newark (7)
Greene, Albert D., 195 Palisade av., Union City (9)
Greenfield, A. W., 50 Anderson st., Hackensack (2)
Greenfield, Bernard H., 691 Clinton av., Newark (7)
Greenfield, Wm. J., 50 Anderson st., Hackensack (2)
Greengrass, Jacob J., 146 Broadway, Paterson (16)
Gregorius, Ralph F., 120 Irvington av., S. Orange (7)
Gregory, Marie F., 50 Gr'n Vill'ge rd., Madison (14)
Gregory, Mildred G., 64 N. 9th st., Newark (7)
Gregory, Roy A., 161 Crescent av., Plainfield (20)
Greifinger, Marcus H., 200 Ferry st., Newark (7)
Grenhart, Geo. W., 430 Haddon av., Camden (4)
Grieco, Emil H., 196 Broadway, Bayonne (9)
Grier, R. M., 50 E. Washington av., Pleasantville (1)
Griesemer, Z. L., 1145 E. Jersey st., Elizabeth (20)
Grieve, Jas., 88 Market st., Perth Amboy (12)
Griffin, Guy B., 197 S. Centre st., Orange (7)
Griffith, Roy, 909 Broad st., Newark (7)
Grimes, Jesse R., 214 Washington av., Dumont (2)
Griswold, Merton L., Jr., 949 Park av., Plainf'ld (20)
Groeschel, August H., 31 Bank st., Sussex (19)
Groff, P. A., 159 Washington av., Little Ferry (2)
Grossblatt, Philip, 70 Baldwin av., Newark (7)
Grossman, Rubin, 81 Somerset st., Garfield (2)
Gruhler, Jean A., 5407 Atl. av., Atlantic City (1)
Guertin, Diomede, N. J. State Hos., Marlboro (13)
Guglielmelli, A. D., 449 Hamilton av., Trenton (11)
Guidi, Guido M., 212 Christine st., Elizabeth (20)
Guidotti, Frank P., 432 Hamilton av., Trenton (11)
Guillium, Wm. H., 505 Fourth av., Asbury Park (13)
Guion, Edward, Atlantic County Hos., Northfield (1)
Guthrie, Wilson G., 300 Summer ave., Newark (7)
Gutmann, Erwin K., 229 Bowers st., Jersey City (9)
Gutowski, Jos. M., 433 Brace av., Perth Amboy (12)
Gutowski, Walter T., 104 Grove ter., Irvington (7)

ASSOCIATE MEMBERS

Gelb, Jerome, 84 W. Alpine st., Newark (7)
Gessner, Gerard R., 28 S. 3rd av., Highland Pk. (12)
Giannetti, E. D., 180 Glen Ridge av., Montclair (7)
Glazier, Jesse T., 670 Sanford av., Irvington (7)
Goldsmith, Alfred, 240 29th st., Woodcliffe (9)
Gross, Isadore, 60 Lakeside av., Verona (7)
Grunt, Louis, 404 Bergen st., Newark (7)
Gulick, Jas. B., 144 S. Harrison st., E. Orange (7)
Gullard, E. G., 205 Alexander av., Montclair (7)
Gurshman, Sol, 280 Amboy av., Metuchen (12)

ACTIVE MEMBERS

Hackett, Edw. J., 566 Westfield av., Westfield (20)
Hackett, L. W., 173 Belvidere av., Washington (21)
Hadley, C. F., 210 W. Maple av., Merchantville (4)
*Hagerty, John F., 212 W. Market st., Newark (7)
Haggerty, D. Leo, 227 N. Warren st., Trenton (11)
Hagney, Fredk. W., 669 Elizabeth av., Newark (7)
Hahn, Katherine B., 372 Thornden st., S. Orange (7)
Hahn, Wm. H., 372 Thornden st., S. Orange (7)
Haight, H. W., 118 Raritan av., New Brunswick (12)
Haines, Edgar J., Medford (3)
Haines, Emerson S., 901 Grand av., Asbury Pk. (13)
Haines, Evelyn M., 432 Hamilton av., Trenton (11)
Haines, Mable C. S., 600 White Hr. Pk., Audubon(4)
Haines, Wm. H., 600 White Horse Pike, Audubon (4)
Haines, Willits P., 601 9th st., Ocean City (5)
Halbach, Robt. M., 802 Main st., Toms River (15)
Haldeman, Robt. E., Mt. Holly (3)
Hale, H. E., Jr., Battlefield Farm, Princeton (11)
Haley, Paul W., 781 Sanford av., Newark (7)
Hall, Perry O., 254 Union st., Jersey City (9)
Hall, Wayne W., 266 Van Houten st., Paterson (16)
Hall, Winthrop H., 400 Elm st., Westfield (20)
Hallett, Fredk. S., 200 Passaic st., Hackensack (2)
Halligan, Earl J., 254 Montgomery st., Jer. City (9)
Halligan, H. J., 254 Montgomery st., Jer. City (9)
Hallinger, Earl S., 517 Cooper st., Camden (4)
Hallock, W. J., 25 Plainf'ld av., Berkeley H'g"s (20)
Halpern, Herman, 143 Engle st., Englewood (2)
Halpern, Samuel, 504 Pacific av., Atlantic City (1)
Halpern, Sophia L., 271 Palisade av., Union City (9)
Halprin, Harry, 8 Washburn pl., Caldwell (7)
Halsey, Levi W., 61 Churhc st., Montclair (7)
Halsted, Chas. F., 40 Grove st., Somerville (18)
Hamblin, D. O., Calco Chem. Co., Bound Brook (18)
Hambright, Arthur M., 266 Van H'ten st.,P't'rs'n(16)
Hammell, Frank M., 137 S. Main st., Allentown (11)
Hammett, Lee J., 760 N. 27th st., Camden (4)
Hampton, Geo. R., Greystone Park (14)
Hanan, Jas. T., 11 The Crescent, Montclair (7)
Hancock, Michael Q., 705 D st., Belmar (13)
Haney, John J., 167 Cooper st., Trenton (11)
Hanrahan, Jas. M., 1144 E. Broad st., Elizabeth (20)
Hansen, Harry, 831 Madison ave., Plainfield (20)
Hanson, Alfred S., 533 Monmouth st., Gloucester (4)
Hanson, Carl G., 116 Eastman st., Cranford (20)
Hantman, Harold, 530 Orange st., Newark (7)
Harden, Albert S., 510 W. Market st., Newark (7)
Hardenberg, D. S., 347 Communipaw av. Jer. City(9)
Hardy, John W., 53 Main st., Farmingdale (13)
Harhen, Geo. E., 257 Bloomfield av., Caldwell (7)
Harley, H. L., 101 S. Indiana av., Atlantic City (1)
Harman, B. M., Essex Co. Sanatorium, Verona (10)
Harman, Harry M., 25 Bridge st., Frenchtown (10)
Harman, Jas. R., 1819 S. Broad st., Trenton (11)
Harman, Wm. J., 740 W. State st., Trenton (11)
Harmon, Walter H., 116 High st., Hackettstown (21)
Harreys, Chas. W., 714 Broadway, Paterson (16)
Harrington, J. H., 126 E. Main st., Rockaway (14)
Harris, Allan, Greenwich (6)
Harris, Chas. M., 279 Grove st., Jersey City (9)
Harris, Edwin A., 7 Oxford av., Stratford (4)
*Harris, Harry B., 47 Cleveland st., Orange (7)
Harris, Wm. G., Mullica Hill (8)
Harryman, Wm. K., 271 Union st., Hackensack (2)
*Hart, Hugh, Mt. Prospect av., Newark (7)
Harter, Louis F., 174 Bowers st., Jersey City (9)
Hartman, L. M., 82 E. Main st., Maple Shade (3)
Hartwell, H. A., 777 Boulevard, E. Weehawken (9)
Harvey, E. H., 20 N. Florida av., Atlantic City (1)
Harvey, John W., 818 Ave. C, Bayonne (9)
Harvey, Thos. W., Sr., 59 Main st., Orange (7)
Harvey, Thos. W., Jr., 59 Main st., Orange (7)
Haseltine, Sherwin L., 125 Broad st., Elizabeth (20)
Hasking, A. P., 318 Montgomery st., Jer. City (9)
Hasney, Fredk. A., 292 Main st., West Orange (7)
Hatch, H. S., Shonghum Mt. San., Morristown (14)

Hauber, Eugene A., 6 Quaid st., Sayreville (12)
Hauck, L. B., 644 Stuyvesant av., Irvington (7)
Hauck, Wm. H., 644 Stuyvesant av., Irvington (7)
Hausman, S. W., 50 W. Front st., Red Bank (13)
Haussling, Francis R., 661 High st., Newark (7)
Haven, Samuel C., 14 Elm st., Morristown (14)
Hawke, Edw. K., N. J. State Hospital, Trenton (11)
Hawkes, E. Zeh, 84 Washington st., Newark (7)
Hawkes, Stuart Z., 84 Washington st., Newark (7)
Hayden, Walter G., 504 Main st., Toms River (15)
Hayes, Gerald W., 86 Hawthorne av., E. Orange (7)
Hays, Roy G., 567 Haddon av., Collingswood (4)
Haywood, H., 49 Paterson st., New Brunswick (12)
Heath, Louanna, 20 Fairmount av., Newark (7)
Heatley, Wm., 23 Monmouth st., Red Bank (13)
Hegeman, R. F., 161 W. High st., Somerville (18)
Heil, A. Arling, Milford (10)
Heilbrunn, Julius, 135 Belmont av., Jersey City (9)
Heineken, Theo. S., 17 Park pl., Bloomfield (7)
Heinig, Frank G., 124 Cornelia st., Boonton (14)
*Heintzelman, B. S., Weehawken (9)
Hekimian, J. H., 468 Palisade av., Weehawken (9)
Helff, Jos. R., 1367 Teaneck rd., W. Englewood (2)
Heller, Geo., 100 E. Palisade av., Englewood (2)
Heller, Nathan B., 31 Lincoln Park, Newark (7)
Hemphill, E. H., 232 Kings H'way E., Had'nf'ld (4)
Henderson, K. P., 121 S. Illinois av., Atl. City (1)
Henle, Carye Belle, 671 Springfield av., Newark (7)
Henriksen, Jay B., 422 River av., Pt. Pleasant (15)
Henry, F. C., Jr., 214 Smith st., Perth Amboy (12)
Henry, Geo., Flemington (10)
*Henry, Jonas A., Pleasantville (1)
Henshaw, Geo. R., 49 Park st., Montclair (7)
Herbener, Eugene G., 423 Third st., Lakewood (15)
Hermann, John H., 197 S. Centre st., Orange (7)
Hernandez, Manuel, 1974 Hudson Blvd., Jer. City (9)
Herndon, Lewis S., 33 Johnson av., Newark (7)
Herradora, U. J. R., 2787 Boulevard, Jer. City (9)
Herrington, Lee R., 605 E. Broad st., Westfield (20)
Herrman, Wm. G., 501 Grand av., Asbury Park (13)
Hersh, David H., 658 Springfield av., Newark (7)
Hersohn, Wm. W., 116 S. Illinois av., Atl. City (1)
Hess, Geo. A., River rd., Titusville (11)
Hess, L. Elmore, 19 E. Bolton av., Absecon (1)
Hessert, E. C., 700 Haddon av., Collingswood (4)
Hewson, Geo. F., 21 Roseville av., Newark (7)
Hexamer, Fred, 50 Lyons av., Newark (7)
Heyman, Arthur, 79 Baldwin av., Newark (7)
Hicks, Al. M., 65 N. Fullerton av., Montclair (7)
Hicks, Wm. H., 46 Milford av., Newark (7)
Hiden, Jos. C., 199 Nassau st., Princeton (11)
Higgins, Gerald L., 94 Lembeck av., Jersey City (9)
Higgins, Thos. F., 146 Reid st., Elizabeth (20)
Hiler, Stuart A., 62 Rockaway av., Rockaway (14)
Hilker, Geo. F., 258 Maple st., Perth Amboy (12)
Hill, John A., 511 Cedar av., Allenhurst (13)
Hill, Robt. H., 332 Park av., Newark (7)
Hill, Wm. F., 108 Grand st., Jersey City (9)
Hillegass, Eugene Z., Mantua (8)
Hillel, Jos., 1394 Park av., Hudson Heights (9)
Hilliard, Wm. T., 105 Market st., Salem (17)
Hilton, Clarence O., 556 N. 7th st., Newark (7)
Hinton, Samuel H., 6 Washington rd., Parlin (12)
Hipple, Percy L., Jr., 230 Walnut st., Roselle (20)
Hird, E. F., 118 E. Maple av., Bound Brook (18)
Hirschfield, B. A., 1404 Green w'd av., Trenton (11)
Hirst, Ernest R., 634 Federal st., Camden (4)
*Hirst, Levi B., 634 Federal st., Camden (4)
Hitzemann, L. A., 30 E. Passaic st., Mawyood (2)
Hnat, Fredk., 471 Madison av., Elizabeth (20)
*Hoagland, L. B., Oxford (21)
Hobart, Richard T., 454 Park st., Up. Montclair (7)
Hoffman, Chas. A., 302 E. 7th st., Plainfield (20)
Hoffman, F. M., 91 Bayard st., New Brunswick (12)
Hoffman, Harry S., 1902 Pacific av., Atlantic C'y (1)
Hoffman, Peter, Jr., 2672 Boulevard, Jersey City (9)
Hogan, Marshall D., 219 Main st., Boonton (14)
Hoheb, Alberto S., 5 Lincoln av., Rutherford (2)
*Holden, Edgar J., 217 Broadway, Newark (7)
Holland, Geo. A., 364 Clinton av., Newark (7)
Holland, John A., 54 Prospect st., Trenton (11)
Holland, Rueben J., 1026 Chandler av., Linden (20)
Holler, Henry G., 234 Montclair av., Newark (7)
Hollingshead, Lyman B., Pemberton (3)
Hollinshed, Beulah S., 600 Benson st., Camden (4)
Hollinshed, Ralph K., 351 Broadway, Westville (8)
Hollywood, J. L., 1818 Hudson blvd., Jer. City (9)
Holman, Francis W., 123 Broad st., Keyport (13)
Holmes, Geo. J., 17 Elizabeth av., Newark (7)
Holmes, Grace A., 1077 E. Jersey st., Elizabeth (20)
Holmes, Thos. J. E., 151 Fair st., Paterson (16)
Holoman, M. B., 3 N. Granville av., Margate (1)
Holt, E. Z., Children's Seashore Home Atl. City (1)
Holt, Evelyn, 118 Summit av., Summit (20
Holt, Herman H., 258 Graham av., Paterson (16)
Holtzman, Michael, 167 Second st., Elizabeth (20)
Holters, Otto R., 1002 Emory st., Asbury Park (13)
Hoops, Harold J., 2203 Blvd., Jersey City (9)
Hoover, Alden R., 721 N. Broad st., Elizabeth (20)
Horland, Aaron H., 24 Stengel av., Newark (7)
Horn, Max, 94 Lyons av., Newark (7)
Hornberger, Jennings H., Roebling (3)
Horner-Rodger, Clara L., 721 Cooper st., Camden(4)
Hornstine, H. H., Young & Pacific aves., Wildw'd (5)
Horowitz, Herman J., 872 Broad av., Ridgefield (2)
Horre, Geo. W. H., 203 W. Jersey st., Elizabeth (20)
Horsford, Fredk. C., 305 Broadway, Newark (7)
Hosp. Paul H., 842 S. 12th st., Newark (7)
Houck, Wm. J., 207 Mt. Prospect av., Newark (7)
Howard, J. E., 67 King's Highway, W.,Had'nf'ld (4)
Howard, Jas. W., 31 The Crescent, Montclair (7)
Howeth, John L., 14 Duncan av., Jersey City (9)
Howley, B. M., 419 George st., New Brunswick (12)
Hubach, M. F., Jr., 307 Montgomery st., Bl'mf'ld (7)
Hubbard, Fayette E., 65 Church st., Montclair (7)
Hubbard, Harry V., 121 E. 7th st., Plainfield (20)
Hubbard, Robt. Y., 12 Myrtle av., Irvington (7)
Huber, Wm. H., 15 Salem st., Newark (7)
Huberman, John, 853 E. 12th st., Newark (7)
Hubert, Antonio O., 131 E. Main st., Rockaway (14)
Hudson, W. J., 123 W. Wash'gt'n av., Pl's'ntv'le (1)
Huff, Edmund N., 97 Engle st., Englewood (2)
Hughes, F. R., Columbia av., & Oc'n st., C'pe M'y(5)
Hughes, Frederic J., 706 Park av., Plainfield (20)
Hughes, Joseph F., 116 N. Broad st., Woodbury (8)
Hughes, John V., 657 Main av., Passaic (16)
Hughes, Lee W., 965 Broad st., Newark (7)
Hughes, Thos. E., 223 Cooper st., Camden (4)
Hulett, Albert G., 20 Hawthorne av., E. Orange (7)
Hull, Donald B., 7 W. Ridgewood av., Ridgewood (2)
Hummel, Ernest G., 414 Cooper st., Camden (4)
Hummel, I. L. C., 109 W. Broadway, Salem (17)
Hummel, M. L.. 135 N. Centre st., Merchantville (4)
Humphries, Robt. E., 637 Central av., E. Orange (7)
Hunt, Melvin M., 140 Jackson st., South River (12)
Hunt, Thos. F., 528 Monroe av., Elizabeth (20)
Hunter, Edward R., Delanco (3)
Hunter, F. D., 3620 Not'gh'm way, Hamilton Sq.(11)
Hurff, Jos. W., 86 Washington st., Newark (7)
Husserl, Siegfried, 777 Clinton av., Newark (7)
Husted, Samuel H., Neshanic (18)
Hutcheson, Chas. R., 517 Cooper st., Camden (4)
Hutchinson, A. D., 913 W. State st., Trenton (11)
Hutchinson, G. F., 55 Mercer st., Hamilton Sq. (11)
Hutton, Fredk. T., 1012 Park av., Plainfield (20)
Hyer, Oscar H., 210 Main st., Matawan (13)
Hyman, Chas., 2619 Pacific av., Atlantic City (1)
Hymowitz, Ben., 519 Belmont av., Newark (7)

ASSOCIATE MEMBERS

Haller, Abraham R., 10 Kearny av., Kearny (7)
Halpern, M. M., 493 Central av., Newark (7)
Hamilton, R. G., 92 Main st., Orange (7)
Harden, Albert S., 510 W. Market st., Newark (7)
Harreys, Chas. W., 714 Broadway, Paterson (2)
Harvey, B., 92 Forest st., Kearny (7)
Harz, Wm. V., 817 Ave. C, Bayonne (9)
Heller, Abraham R., 10 Kearny av., Kearny (7)
Hennig, Paul F., 688 Stuyvesant av., Irvington (7)
Hickey, C. M., 464 Churchill rd., W. Englew'd (2)
Higgins, John T., 145 Highland av., Jersey City (9)
Hooton, Thomas C., 56 Church st., Montclair (7)
Horhovitz, Geo. I., 324 S. Broad st., Trenton (11)
Hutner, C. I., Perth Amboy Gen. Hos., P.Amboy(12)

ACTIVE MEMBERS

Iams, S. H., Liberty pl. & Wescott rd., Princet'n(11)
Ianacone, John A., 310 Fifth av., Paterson (16)
Ill, Carl H., 188 Clinton av., Newark (7)
Ill, Chas. L., 188 Clinton av., Newark (7)
Ill, Edgar A., 1004 Broad st., Newark (7)
Ill, Edward J., 1004 Broad st., Newark (7)
Ill, Herbert M., 188 Clinton av., Newark, (7)
Imbleau, Jos. E. L., 2106 Morris av., Union (20)
Imhoff, Robt. E., 29 E. Main st., Moorestown (3)
Infield, G. L., 1401 Shore rd., Northfield (1)
Inge, Theo. R., 366 Halsted st., E. Orange (7)
Ingling, Harry W., 51 W. Main st., Freehold (13)
Introcaso, D. A., 45 Crescent av., Jersey City (9)
Ireland, Allen G., 28 W. State st., Trenton (11)
Irvin, John S., 1910 Pacific av., Atlantic City (1)
Irving, A. S., 318 Howard av.,Radburn-Fairlawn(16)
Irwin, Jas. R., 330 Washington av., Belleville (7)
Irwin, John H., 51 Tenafly rd., Englewood (2)
Iannuzzi, Ernesto, 597 Palisade av., Cliffside Pk. (2)
Iserman, Michael, 209 Westfield av., Elizabeth (20)
Ishkhanian, N. I., 656 Palisade av., W. New York (9)
Israeloff, Howard H., 1044 Clinton av., Irvington (7)
Ives, Edwin I., 24 Stevens av., Little Falls (16)
Ivins, Wm. C., 214 E. Hanover st., Trenton (11)
Ivory, Harry S., 616 Forman av., Pt. Pleasant (15)

ASSOCIATE MEMBERS

Inge, G. A. L., 150 Winthrop rd., Englewood (2)

ACTIVE MEMBERS

Jablonski, J. J., 100 Main st., Sayreville (12)
Jack, H. Wesley, 517 Cooper st., Camden (4)
Jacks, Oscar, 476 Mercer st., Jersey City (9)
Jackson, Albert F., 225 Hillside av., Nutley (7)
Jackson, Chas. H., 1250 Park Blvd., Camden (4)
Jackson, D. P. D., 420 Front st., Belvidere (21)
*Jacob, Albert, Sparta (19)
Jacobs, Alan L., 2130 Morris av., Union (20)
Jacobson, J. J., 1616 Pacific av., Atlantic City (1)
Jacobson, M. B., 241 State st., Perth Amboy (12)
Jaffe, Benjamin, 568 Bergen av., Jersey City (9)
Jaffe, Herman M., 2600 Blvd., Jersey City (9)
Jaffin, Abraham E., 41 Emory st., Jersey City (9)
Jahn, Albert G., 657 Main av., Passaic (16)
James, Bart M., 31 Lincoln Park, Newark (7)
James, Wm. H., Main st., Pennsville (17)
James, Wm. L., 31 Lincoln Park, Newark (7)
Jamison, Wm. F., 501 Grand av., Asbury Pk. (13)
Jani, Frank F., 297 Lexington av., Passaic (16)
Jaques, J. Eugenia, 74 Waverly st., Jersey City (9)
Jarmulowsky, Harry, 181 E. 33rd st., Paterson (16)
Jarrett, Harry, 923 Broadway, Camden (4)
Jaso, Jas. V. Di, 710 Varsity rd., So. Orange (7)
Jaspan, Samuel C., 820 Division st., Trenton (11)
Jedel, Meyer, 125 Fourth st., Newark (7)
Jehl, Jos. R., 305 Clifton av., Clifton (16)
Jenkins, Edw. J., Mt. Pleasant av., Whippany (14)
Jennings, Robt. E., 143 Park st., East Orange (7)
Jensen, Grover H., 169 Lexington av., Jer. City (9)
Jentz, John H., 67 Sherman pl., Jersey City (9)
Jessurun, Samuel H., 613 High st., Newark (7)
Joelson, Morris S., 577 Broadway, Paterson (16)
Joffe, Sidney H., 556 E. 28th st., Paterson (16)
Johnsen, Sigurd W., 49 Passaic av., Passaic (16)
Johnson, Chas. H., 632 Benson st., Camden (4)
Johnson, Geo. F., Branchvillle (19)
Johnson, G. L. Jr., 390 Booth ave., Englewood (2)
Johnson, Harold F., 734 Park av., Plainfield (20)
Johnson, V. Earl, 101 S. Indiana ave., Atl. City (1)
Johnston, Julian F., 17 Van Doren av., Chatham(14)
Johnston, Rufus O., Railroad av., Harrington Pk. (2)
Johnston, Sidney F., 365 Rochelle av.,RochelleP'k(2)
Jonas, August E., 218 Pine av., Wildwood (5)
Jones, Ed. C., 183 Grove st., Montclair (7)
Jones, Granville L., N. J. State Hosp., Marlboro (13)
Jones, Herbert E., 47 Elm st., Elizabeth (20)
Jones, John M., Valley rd., R.F.D., Oakland (9)
Jones, John C., 805 Princeton av., Camden (4)
Jones, Lewis H., 139 Grant av., Roselle Park (20)
Jonitz, Robt., 157 Grove st., East Orange (7)
Jordan, Jos. C., 238 E. Main st., Manasquan (13)
Joseph, Benj. M., 2771 Boulevard, Jersey City (9)
Joseph, Morris, 271 Lexington av., Passaic (16)
Judge, John F., 33 Hazelwood av., Newark (7)
Jukofsky, Isidore, 32 Union pl., Ridgefield Pk. (2)
Just, Francis, 564 High st., Newark (7)
Justin, Arthur W., 41 Fulton st., Weehawken (9)
Justin, J. Clement, 1074 Dearborn rd., Palisade (9)

ASSOCIATE MEMBERS

Jacobs, William, 360 Broad st., Newark (7)
James, Wm. L., 31 Lincoln Park, Newark (2)

ACTIVE MEMBERS

Kachdorian, Vartan, 930 Brunswick av., Trent'n(11)
Kaderabek, Erwin J., 144 Harrison st., E. Orange(7)
Kahn, Leo, 32 States av., Atlantic City (1)
Kahrs, Grace M., 375 Mt. Prospect av., Newark (7)
Kaighn, Chas. B., 905 Pacific av., Atlantic City (1)
Kain, Thos. M., 403 Cooper st., Camden (4)
*Kain, Wm. W., Cape May Court House (4)
Kakascik, Emil, 206 Palisade av., Garfield (2)
Kalb, Samuel W., 416 Clinton pl., Newark (7)
Kalter, Geo. E., 640 Prospect st., Maplewood (7)
Kanning, Fredk. R., W. Allendale av., Allendale (2)
Kanses, Edmund S., 51 West River rd., Rumson (13)
Kaplan, Herman B., 324 44th st., Union City (9)
Kaplan, S. Bernard, 860 S. 11th st., Newark (7)
Kapp, Carl G., 440 Westminster av., Elizabeth (20)
Karshmer, Ernest E., 927 S. Wood av., Linden (20)
Kastler, Franz, 54 Ames av., Rutherford (2)
Katzin, Eugene M., 50 Baldwin av., Newark (7)
Kauffmann, Louis J., 232 North 2nd st., Millville (6)
Kaufman, Jerome G., 299 Clinton av., Newark (7)
Kaufman, Michael J., 103 Lyons av., Newark (7)
Kavanaugh, Daniel E., 217 Broadway, Newark (7)
Kay, C. Robt., Peapack (18)
Kazmann, Harold A., 406 Broadway, L'g Branch(13)
Kearney, Edward P., 26 Forest st., Montclair (7)
Keating, Chas. A., 177 Ellison st., Paterson (16)
Keegan, Thos. D., 8 Gifford av., Jersey City (9)
Keeney, Cadwell B., 137 Summit av., Summit (20)
Keim, Wm. F., 25 Roseville av., Newark (7)
Keir, Floyd E., 308 Engle st., Englewood (2)
Keller, Franklin J., 297 D'm'd Br. av., Hawth'rne(16)
Keller, Paul, 15 Washington st., Newark (7)
Keller, Sidney C., 31 Lincoln Park, Newark (7)
Kelley, Chas. B., 921 Bergen av., Jersey City (9)

Kelly, Bernard S., 1954 Boulevard, Jersey City (9)
Kelly, H. R. J., 311-A Brown st., Union City (9)
Kemper, Harry E. T., 224 Monmouth rd.,Eliz'b'h(20)
Kennedy, Eugene T., 413 W'n'que av.,P'mt'nLk.(16)
Kennedy, Paul A., 58 Tenafly rd., Englewood (2)
Kennedy, Wm. M., Essex Mt. Sanatorium,Verona(7)
Kenney, John A., 134 W. Kinney st., Newark (7)
Kenyon, Thomas A., 14 4th st., Weehawken (9)
Keppler, Chas., Jr., 723 Allwood rd., Clifton (16)
Kern, E. Clarence, 45 Park st., Montclair (7)
Kerns, Francis J., 526 W. Market st., Newark (7)
Kessell, John S., 643 Central av., East Orange (7)
Kessler, Henry B., 666 Clinton av., Newark (7)
K ssler, Henry H., 53 Lincoln Park, Newark (7)
Keyser, David, W. Jer. HomeopathicHos.,C'md'n((4)
Kiely, Eugene M., 926 Hudson st., Hoboken (9)
Kilduffe, Robt. A., At. C'y Hosp., Atlantic City (1)
Kiley, John E., 31 Lincoln Pk., Newark (7)
Kim, Gay B., 528 Totowa rd., Totowa (16)
Kimmel, M. Leonard, 142 Manhattan av., Jer. C'y(9)
Kinch, Fred'k A., 267 E. Broad st., Westfield (20)
King, Alden P., 44 Blackwell st., Dover (14)
King, Chester A., 410 Kinderkamack rd., Oradell (2)
Kingslow, Geo. L., 346 First st., Hackensack (2)
Kinney, Albert G., 917 Haddon av., Collingsw'd (4)
Kinney, Burton O., 41 Lincoln av., Little Falls (16)
Kinney, Seldon T., 250 Main st., South Amboy (12)
Kirchner, M. T., Vernon (19)
Kirkby, Cyril S., 98 Broad st., Bloomfield (7)
Kirkman, Leroy G., 176 Roseville av., Newark (7)
Kirkwood, Allan S., 53 Union st., Montclair (7)
Kirschner, Martin I., Vernon (19)
Klaus, Henry, 435 Palisade av., Union City (9)
Kleiber, Estelle E., 139 New st., New Brunsw'k (12)
Klein, Edward C., Jr., 209 Littleton av., Newark (7)
Klein, Edward F., 136 Market st., P. Amboy (12)
Klein, Wm., 85 Bayard st., New Brunswick (12)
Kleiner, Samuel, 162 Hamilton av., Paterson (16)
Kleinman, Maurice, 198 Avon av., Newark (7)
Klempner, Paul, 414 Market st., Trenton (11)
Klenk, Jos. P., 328 Belleville av., Bloomfield (7)
Kler, Jos. H., 77 Livingston st., New Brunswick (12)
Kline, Herman, 2627 Pacific av., Atlantic City (1)
Kline, Oram R., 414 Cooper st., Camden (4)
Klugman, Louis, 696 Ave. C, Bayonne (9)
Knapp, Richard E., 25 Hudson st., Hackensack (2)
Knapp, Victor, 505 Second av., Asbury Park (13)
Knauer, Geo., 930 Elizabeth av., Elizabeth (20)
Knepper, Orcena F., 149 Crescent av., Plainfield (20)
Knight, Augustus S., Far Hills (18)
Knight, I. Warner, Pitman (8)
Knight, Wm. T., Jr., 515 Oradell av., Oradell (2)
Knowles, Fredk. E., 103 Church st., Boonton (14)
Knowles, Geo. M., 241 Main st., Hackensack (2)
Knowles, Jas. S., 318 North 2nd st., Millville (6)
Knox, Chas. A., 138 Bergen av., Ridgefield Park (2)
Knox, Harriet L., 390 Union st., Hackensack (2)
Knox, Howard A., New Hampton (10)
Koelsch, Fredk. J., 14 Kirk'tr'k st., N. Brunsw'k (12)
Koenig, Bertram, 306 Broadway, Paterson (16)
Koerber, Geo., 136 Prospect st., Passaic (16)
Kolb, John M., 725 10th st., Union City (9)
Kolodin, Abraham, 146 Franklin st., Bloomfield (7)
Kondor, Jos. S., 978 S. Broad st., Trenton (11)
Konzelmann, Henry J., 65 King st., Hillside (20)
Kooperstein, Samuel I., 395 Ogden av., Jer. C'y (9)
Koplin, Nathaniel H., 142 W. State st., Trenton (11)
Koppel, Jos. A., 921 Bergen av., Jersey City (9)
Koppel, Leopold A., 921 Bergen av., Jersey City (9)
Kossmann, W. J., Long Valley (14)
Kovarsky, Albert E., 255 State st., Perth Amboy (12)
Kraczyk, M. J., 200 Whitehead av., South River (12)
Kraemer, Manfred, 31 Lincoln Park, Newark (7)
Kraemer, Samuel H., 309 Baldwin av., Jer. City (9)
Kraissl, Cornelius J., 393 Main st., Hackensack (2)
Kraker, David A., 31 Lincoln Park, Newark (7)
Kramer, Douglas W., 822 Park av., Plainfield (20)
Kramer, Samuel E., 121 Market st., Perth Amb'y(12)
Krans, Clara DeHart, 920 Park av., Plainfield (20)
Krans, Edw. S., 920 Park av., Plainfield (20)
Krauss, Fletcher I., 201 Main st., Chatham (14)
Krausz, Emery, 577 S. Main st., Phillipsburg (21)
Kraut, Arthur, 2801 Boulevard, Jersey City (9)
Krechmer, Abraham, 521 Pacific av., Atl. City (1)
Kresch, Philip, 42 W. 22nd st., Bayonne (9)
Kreutz, Paul J., 363 Union av., Elizabeth (20)
Krohn, Marc, Campbell av., Belford (13)
Kroll, Mark M., Union av., Cresskill (2)
Krone, Wm. F., 31 Lincoln Park, Newark (7)
Kruger, Wm., 31 Lincoln Park, Newark (7)
Kuchlewski, Edward J., 130 Third st., Elizabeth (20)
Kuder, Jos. M., 104 Garden st., Mt. Holly (3)
Kuhl, John P., 38 Main st., Butler (16)
Kuhlmann, Alvin E., 527 37th st., Union City (9)
Kuite, Geo. B., 435 Speedwell av., Morris Plains (14)
Kummel, Max, 31 Lincoln Park, Newark (7)
Kushner, Alexander, 208 W. Milton av., Rahway(20)
Kustrup, John F., 1418 S. Broad st., Trenton (11)
Kutner, Chas., 1005 S. 5th st., Camden (4)
Kyle, Ernest I., 1165 Park av., Plainfield (20)

ASSOCIATE MEMBERS

Klein, Andrew J. V., 209 Littleton av., Newark (7)
Kleinberger, H. H., 59 Main st., Millburn (7)
Kline, Geo. L., 146 N. Grove st., East Orange (7)
Kohn, Jos J., 207 Calhoun st., Trenton (11)
Kohn, L., 310 S. Orange av., South Orange (7)

ACTIVE MEMBERS

Laauwe, Harold W., 198 Haledon av., Prosp't Pk.(16)
Labash, Chas., 83 Quincy st., Passaic (16)
Labow, Jos. J., 1063 E. Jersey st., Elizabeth (20)
Ladas, Geo., 305 Cherry st., Elizabeth (20)
Lafferty, Elton B., 330 Myrtle av., Irvington (7)
Laird, Geo. S., 125 Central av., Westfield (20)
Lamy, Anthony W., 560 Newark av., Elizabeth (20)
Lance, Elton W., 125 W. Milton av., Rahway (20)
Landaw, Louis, 669 Broadway, Paterson (16)
Landes, Edwin W., Stillwater (19)
Landshof, Chas. A., 50 Glenwood av., Jersey City (9)
Lane, Arthur G., Greystone Park (14)
Lane, Austin W., 98 Prospect st., East Orange (7)
Lane, Edgar W., Bloomsbury (10)
Lane, Frank B., 98 Prospect st., East Orange (7)
Lange, Louis C., 50 Clifton ter., Weehawken (9)
*Lansing, T. B., Pine Rest, Tenafly (2)
Lapin, Samuel B., 542 W. State st., Trenton (11)
Largay, Arthur O., 937 Ave. C, Bayonne (9)
La Riew, Fred J., 107 E. Wash'gt'n av.,W'sh'gt'n(21)
Larkey, Chas. J., 700 Ave. C, Bayonne (9)
Larossa, Ernest A., 708 Cooper st., Camden (4)
Larrabee, C. H., 14 Kent pl. blvd., Summit (20)
Larson, Henry M., 35 Franklin st., Morristown (14)
Lathrop, Frederic W., 507 Park av., Plainfield (20)
Lathrope, Geo. H., 965 Broad st., Newark (14)
Laurie, Andrew L., 664 Newark av., Elizabeth (20)
Lavine, Barney D., 630 N. Clinton av., Trenton (11)
Lawrence, Elias D., 365 Union st., Paterson (16)
Lawrence, Wm. H., 129 Summit av., Summit (20)
Lawsing, Geo. C., 443 22nd st., West New York (9)
Lawton, A. Anderson, 15 N. Bridge st.,Somerv'le(18)
*Leavitt, John F., 522 N. 3rd st., Camden (4)
Le Bel, Louis J. B., 165 Grant av., Nutley (7)
Lee, John J., 66 Central av., Orange (7)
Lee, Stephen G., 55 Halsted st., East Orange (7)
Lee, Thos. B., 622 Cooper st., Camden (4)
Le Favor, Dean H., 619 Morgan av., Palmyra (3)
Lefkowitz, J. H., 445 20th st., West New York (9)

Legato, Samuel F., 417 Palisade av., Cliffside Pk.(2)
Leggett, Lindley H., Jr., 330 E. Broad st.,W'stf'd(20)
Leggett, Thos. H., Jr., 706 Park av., Plainfield (20)
Lehmacher, Frank, 18 Central av., Lakewood (15)
Lehman, Irving J., 558 Central av., Newark (7)
Leighton, Robt. L., 401 Ludlow av., Spring Lake (13)
Leining, Albert, 1 Fourth st., Weehawken (9)
Leir, J. Krevin, 9 Garrison av., Jersey City (9)
Lemay, Albert T., 384 15th av., Paterson (16)
Lemmerz, Theodore H., 141 Magnolia av., Jer. C'y(9)
Lemmon, Junius M., 26 W. W'sh'gt'n av., W'gt'n(21)
Leonard, Edward F., 771 Madison av., Paterson (16)
Leonard, Geo. F., 65 N. 5th av., New Brunsw'k (12)
Leonard, Isaac E., 2842 Atlantic av., Atlantic C'y(1)
Leonard, Lothair L., 615 Asbury av., Asbury P'k(13)
Leonardis, Jas. V., 94 Jefferson st., Newark (7)
Lepree, Jos. A., 371 Morris av., Elizabeth (20)
Lerman, Irving, 1024 E. Jersey st., Elizabeth (20)
Lesh, Vincent O., 114 S. Stevens av., S. Amboy (12)
Lesko, Stephen W., 663 Main av., Passaic (2)
Lettiere, Anthony J., 425 E. State st., Trenton (11)
Levendusky, Daniel E., 52 Market st., Passaic (16)
Levin, Jos., 831 South 13th st., Newark (7)
Levin, Louis, 140 W. State st., Trenton (11)
Levine, David B., 647 Broadway, Paterson (16)
Levine, Edward P., 86 Clinton av., Newark (7)
Levine, G. Irving, 2017 Boulevard, Jersey City (9)
LeVine, Israel, 215 Broadway, Paterson (16)
Levine, Sidney C., 459 Park av., Paterson (16)
Levinsohn, Sandor A., 584 Broadway, Paterson (16)
Levinson, Louis J., 18 Stratford pl., Newark (7)
Levitas, Geo. M., 77 Fairview av., Westwood (2)
Levitas, Irving M., 77 Fairview av., Westwood (2)
Levitt, Jesse N., 26 Clinton pl., Newark (7)
*Leyenberger, S. B., Newark (7)
Levy, Abram, Bound Brook (18)
Levy, Herman, 219 Lexington av., Passaic (16)
Levy, Irvin, 329 Gardner av., Trenton (11)
Levy, Julius, 202 Osborne ter., Newark (7)
Lewandowski, S S., 1450 Mt. Ephraim av., C'md'n(4)
Lewis, Albert, 41 Retford av., Cranford (20)
Lewis, Alice B., E. Saddle River rd., Saddle River(2)
Lewis, Geo. R., 458 Washington av., Belleville (7)
Lewis, Leon, 190 Clinton av., Newark (7)
Lewis, Livingstone L., 712 W'sh'gt'n st., Hob'k'n(9)
Lewis, Thos. K., 47 S. 27th st., Camden (4)
Liccese, Emanuel, 635 Summer av., Newark (7)
Lieberman, David P., 1063 North av., Elizabeth (20)
Lieberman, Milton L.,101Pershing av.,RosellePk.(20)
Lief, Lawrence H., 41 Railroad av., Jamesburg (12)
Linares, Angelo C., 208 Market st., Paterson (16)
Lincoln, Jennings S., 140 Watch'ng av., U. Mont.(7)
Lindblade, E. H., 389 Grove st., Up. Montclair (7)
Linden, Mortimer H., 45 Clendenny av., Jer. City (9)
Lindroth, Lawrence V., 624 Pavonia av., Jer. C'y(9)
Linke, J. J. P., 245 E. Front st., Plainfield (20)
*Lippincott, A Haines, 406 Cooper st., Camden (4)
Lipschutz, Chas., 804 Ave. C, Bayonne (9)
Lisanti, Gaetano, 660 Tyler pl., West New York (9)
Little, Alonzo W., Jr., 120 Arlington av., Jer. City(9)
Little, Wm. R., 493 W. State st., Trenton (11)
Littwin, Chas., 962 Queen Anne rd., Teaneck (2)
Liva, Arcangelo, 5 Pangborn pl., Hackensack (2)
Liva, G. Albin, Madison & Franklin avs., Wyckoff(2)
Livengood, Baxter A., 406 Second st., Swedesboro(8)
Livengood, Horace R., 587 Westminster av., Eliz.(20)
*Livingston, Jacob, Newark (7)
Lloyd, Reba Krump, 31 W.Commerce st.,Bridg't'n(6)
Llull, Gabriel J., 271 Morris av., Springfield (20)
Lobsenz, Nathan P., 294 Broadway, Paterson (16)
Loder, Horace B., 225 E. Commerce st., Bridg't'n(6)
Loder, Jos. S., 924 S. 17th st., Newark (7)
Loeser, Lewis H., 31 Lincoln Park, Newark (7)
Lomauro, Jas. R., 149 Lexington av., Passaic (16)
London, Wm., 255 State st., Perth Amboy (12)
Londrigan, Jos. F., 535 Washington st., Hoboken (9)
Long, Herbert W., 102 Jefferson st., Newark (7)
Long, Miles T., 2150 Boulevard, Jersey City (9)
Long, Pauline A., 22 Livingston av., N. Bruns. (12)
Long, Wm. H., 40 S. Bridge st., Somerville (18)
Longnecker, John E, Jr., Sparta (19)
Longsdorf, Harold E., Mt. Holly (3)
Loper, John C., 129 Atlantic st., Bridgeton (6)
Lore, Harry E., Cedarville (6)
Lorenzo, Michael J., 75 Riverside av., Red Bank (13)
Losada, Camella A., 19 Prospect st. ,Summit (20)
Lottridge, Dorothy, 43 S. Maple av., East Orange(7)
Love, Elizabeth F., 142 E. Oak av., Moorestown (3)
Lovejoy, Jas. L., 224 Somerset st., Bound Brook (18)
Lovell, Fredk. H., 1013 Clinton av., Irvington (7)
Lovell, John F., 1011 Clinton av., Irvington (7)
Lovett, Jos. C., Municipal Hospital, Camden (4)
Low, Donald B., 529 Broadway, Paterson (16)
Lowell, Milton E., 434 Summit av., Westfield (20)
Lowenstein, Harry A., 96 Milford av., Newark (7)
Lowrey, Jas. H., 79 Congress st., Newark (7)
Luban, Benjamin, 730 High st., Newark (7)
Lucas, Henry H., 266 Van Houten st., Paterson (16)
Lucas, Wm. F., 23 W. Broad st., Burlington (3)
Lucent, S. Bell, 2 First av., Little Falls (16)
Lucas, Stanley L., 44 N. Kentucky av., Atl. City (1)
Luczynski, Edw. W., 28 E. 22nd st., Bayonne (9)
Lueddecke, R'wl'nd E., 216R'nd'lph av.,E.R'th'rf'd(2)
Lufburrow, Chas. B., 441 W. Front st., Plainfi'd(20)
Luippold, Eugene J., 85 Columbia ter., Weeh'wk'n(9)
Lukats, Elmer J., St. Vil. for Epilep., Skillman (18)
Luksteid, Casimir J., 282 Broadway, Paterson (16)
Lummis, C. Percy, 40 Delaware av., Pennsgrove (17)
Lummis, Marshall F., 10 S. Broadway, Pitman (8)
Lund, John L., 267 High st., Perth Amboy (12)
Lundblad, Walter E., 75 Prospect st., E. Orange (7)
Lupin, Edward E.. 727 Ave. C, Bayonne (9)
Lyerly, James M., 1116 Putnam av., Plainfield (20)
Lynch, Ed. T., 748 Livingston rd., Elizabeth (20)
Lynch, Maurice M., 396 Union st., Hackensack (2)
Lynch, Roland J., Mental Dis. Hosp., Secaucus (9)
Lynn, Irving I., 2252 Boulevard, Jersey City (9)
Lyon, Archibald, 115 Ridge rd., N. Arlington (7)
Lyon, Chas. H., 79 Lewis st., Phillipsburg (21)
Lyon, Earl C., 194 E. Commerce st., Bridgeton (6)
Lyon, Leslie C., P. O. Box 63, Magnolia (4)
Lyons, Jas. V., 333 Park av., Orange (7)
Lyons, Romola L. K., 171 M'd'wbr'k rd., Englew'd(2)

ASSOCIATE MEMBERS

Lapin, Louis P., Bordentown (11)
Lavine, Sidney B., 134 W. State st., Trenton (11)
Lawless, Edward T., 85 Warrington pl., E. Or. (7)
Leonard, F. S., 9 Washington st., Tenafly (2)
Liddy, Frank J., 112 Prospect st., Ridgewood (2)
Lifland, B. D., 62 Farley av., Newark (7)
Lilien, Bernard B., 730 Lyons av., Irvington (7)
Lipschutz, Chas., 804 Ave. C, Bayonne (9)
Lowry, Thos., 112 Prospect st., Ridgewood (2)
Lynch, Jas. F., 244 Stegman st., Jersey City (9)

ACTIVE MEMBERS

Maas, Max A., 329 Clinton av., Newark (7)
Mabey, J. Corwin, Clar'm't & Midl'd avs., M'tcl'r (7)
MacAlister, Alexander, 626 Federal st., Camden (4)
MacAlister, Wm. W., 333 VanHouten st.,Paters'n(16)
MacAlpine, Kenneth B., 308 M'nm'th st.,Gl'c'st'rC.(4)
Macaluso, D. C., 7 Hilton st., Belleville (7)
MacArthur, Clymont, 219 Roseville av., Newark (7)
Macaulay, Francis A., 815 Elm av., Teaneck (2)
MacDermid, LyndenE.,605F'rnsw'th av.,B'rd'nt'n(11)
Macdonald, Wentworth S., 56 Church st., M'ntcl'r(7)
MacDonnell, M. J., 24 30th st., Woodcliff (9)

MacDowall, John L., 113 Market st., P. Amboy (12)
Mace, Margaret, 2410 Atlantic av., N. Wildwood (5)
MacFarland, Burr W., 419 W. State st., Trenton (11)
MacGregor, Allan W., 379 Ellison st., Paterson (16)
MacGuffie, Robt. N., 657 Main av., Passaic (16)
MacKellar, Jas. M., 26 E. Clinton av., Tenafly (2)
MacKenzie, Robt. A., 501 Grand av., Asbury P'k (13)
Mackes, Claude B., 46 N. Main st., Woodstown (17)
Mackler, Louis, 705 Pacific av., Atlantic City (1)
Maclay, Jos. A., 239 Broadway, Paterson (16)
MacMillan, C. Wright, 23 Passaic av., Passaic (16)
MacPherson, Elwood H., 34 Rawley pl., Millburn (7)
Madaras, John S., Jr., 870 Ave. C, Bayonne (9)
Madden, Leland S., 21 E. Verona av., Pleasantv'le(1)
Madden, Theophilus W., 16 Frazer av.,Collingsw'd(4)
Madden, Wm. L., 83 Gifford av., Jersey City (9)
Mader, Anthony I., Jr., 430 Union st., Hackensack(2)
Madison, Lewis K., 358 Pacific av., Jersey City (9)
Maffongellie, Jos. A., 494 River st., Paterson (16)
Magee, David M. P., 407 Sewall av., Asbury Park(13)
Magee, Edward S., 604 White Horse pk., Oaklyn (4)
Magee, Henry R., 408 Main st., Hackensack (2)
Magee, Russell S., 201 White Horse pk., Audubon(4)
Magennis, Bryan C., 267 Park av., Paterson (16)
Maggio, Rosario J., 550 Carlton rd., Westfield (20)
Magill, Marcus, 4116 Ventnor av., Atlantic City (1)
Magovern, Thos. F., 228 S. Orange av., S. Orange(7)
Mahaffey, J. Lynn, 406 Warwick rd., Haddonf'd (4)
Maher, John E., 90 Third av., Long Branch (13)
Mahood, Herbert L., 86 Durand rd., Maplewood (7)
Majeski, Henry J., 1015 Brunswick av., Trenton (11)
Major, Morton M., 2703 Pacific av., Atlantic City (1)
Makin, John B., 501 Grand av., Asbury Park (13)
Malatesta, Chas. S., 302 E. 7th st., Plainfield (20)
Malavazos, Antonio, 635 High st., Newark (7)
Maldeis, Albertos M. K., 117 N. 6th st., Camden (4)
Mamlet, Alfred M., 16 Johnson av., Newark (7)
Manahan, Dan'l V., 55 E. Front st., Red Bank (13)
Mancene, Edw. M., 328 Stuyvesant av., Lyndh'rst(2)
Mancusi-Ungaro, Elviro, 268 Mt.Pr'sp't av.,N'w'k(7)
Mancusi-Ungaro, Lodovico,156Mt.Pr'p't av.,N'w'k(7)
Mangelsdorff, Arthur F., Calco Chem.Co.,B'dBr'k(18)
Mangone, Geo. F., 171 Palisade av., Union City (9)
Manly, Thos E., 360 Park av., Paterson (16)
Mann, Jacob J., 255 State st., Perth Amboy (12)
Maps, Howard L., 53 Passaic av., Passaic (16)
Marano, Michael A., 508 4th st., Union City (9)
Maras, Peter E., 80 Tonnele av., Jersey City (9)
Marcarian, Henry G., 904 Cooper st., Camden (4)
Marcy, John W., 117 E. Park av., Merchantville (4)
Marini, Dominick, 40 Henry st., Passaic (16)
Mark, Harry B., Broad & Elm sts., Riverton (3)
Mark, Jos. S., 102 Green st., Woodbridge (12)
Markel, Albert G., 320 Broadway, Paterson (16)
Markley, Luther A., Holy Name Hospital,Tean'ck(2)
Markowitz, Benj. B., 2157 Boulevard, Jersey City (9)
Markowitz, Irwin B., 2157 Boulevard, Jersey City(9)
Markowitz, Louis, 16 Church st., Paterson (16)
Marks, David M., 298 4th st., Jersey City (9)
Marks, Edward G., 655 Kearny av., Arlington (7)
Marlett, Neumann C., 311 Front st., Belvidere (21)
*Marotte, Chas. L., 1417 S. Clinton av., Trenton (11)
Marquis, Dean W., 144 Harrison st., East Orange (7)
Marquis, Wm. J., 198 Clinton av., Newark (7)
Marrocco, Wm. A., 47 Ward st., Paterson (16)
Marsh, Elias J., 400 Van Houten st., Paterson (16)
*Marshak, Martin I., 879 Ave. C, Bayonne (9)
Marshall, Frank A., 440 Palisade av., Weehawken(9)
Marshall, Jos. C., 1517 Pacific av., Atlantic City (1)
Martin, Elizabeth L., 10 Bayard lane, Princeton (11)
Martin, Wm. P., 25 Holland rd., South Orange (7)
Martinetti, Carlo D., 311 Central av., Orange (7)
Martland, Harrison S., 180 Clinton av., Newark (7)
Marts, Geo. H., 956 Park av., Plainfield (20)
Martucci, Louis, 192 Mt. Prospect av., Newark (7)
Marvel, Peter H., 2216 Shore rd., Northfield (1)
Marvin, Dorothy H., 51 Livingston av., N.Bruns.(12)
Mason, Howard B., 90 W. Main st., Freehold (13)
Mason, Jas. H., 1616 Pacific av., Atlantic City (1)
Massengill, Fulton, 125 Harrison st., E. Orange (7)
Massey, John B., 140 Baldwin st., New Bruns. (18)
*Massey, John P., Atlantic City (1)
Masterson, John F., 98 Myrtle av., Irvington (7)
Masucci, Alberico, 34 Ward st., Paterson (16)
Matera, Joseph, 506 Garden st., Hoboken (9)
Matheke, Geo. A., 328 Sussex av., Newark (7)
Matheke, Otto G., 328 Sussex av., Newark (7)
Mathesheimer, Jacob L., 280 Old B'rg'n rd., J. C'y(9)
Matheson, Gilchrist E., 649 Central av., E.Orange(7)
Mathews, Raymond H., 186 South st., Morrist'n(14)
Mathews, Wm. J., 938 Hudson st., Hoboken (9)
Matthews, Clifford B., 1158 E. State st., Trenton (11)
Matthews, Harry E., 504 Hillside av., Orange (7)
Matthews, Leonard M., 657 Main av., Passaic (16)
Matthews, Wm., 139 Broad st., Red Bank (13)
Matthews, Wm. F., 61 S. Fullerton av., Montcl'r(7)
Maturi, Vincenzo, 814 Hudson Blvd., Bayonne (9)
Maurer, Katherine V., 26 Roosevelt av., Liv'gst'n(7)
Maver, Wm. W., 532 Bergen av., Jersey City (9)
Mayhew, Chas. H., 329 Pine st., Millville (6)
McBride, Andrew F., 30 Church st., Paterson (16)
McCabe Thos. S., 913 Broad st., Newark (7)
McCall, Jesse, 12 Church st., Newton (19)
McCallion, Wm. H., 722 Westminster av., Eliz. (20)
McCallum, A. S., 213 Clements Br. rd., Barringt'n(4)
McCamey, Kenneth E., 612 E. 29th st., Paterson (16)
McCandliss, Wm. K., N. J. State Hosp., Trenton (11)
McCarthy, Arthur M., 2772 Federal st., Camden (4)
McCarthy, Geo. L., 496 Union Ave., Paterson (16)
McCarthy, John J., 606 35th st., N. Bergen (9)
McCauley, Francis J., 31 Lincoln Park, Newark (7)
McClintock, Elsie, 1439 Maple av., Hillside (20)
McConaghy, Thos. P., 10th & Cooper sts., Camden(4)
McConoughy, Francis, 1 E. High st., Somerville (18)
McCorkle, Wm. E., Ringoes (10)
McCormack, Frank C., 95 Tenafly rd., Englewood(2)
McCormick, Jas. E., 322 Clinton av., Newark (7)
McCormick, Wm. H., Jr., 266 Market st., P. Am.(12)
McCoy, John C., 292 Broadway, Paterson (16)
McCroskery, Jas. H., 396 N. Arlington av., E. Or.(7)
McCue, John B., 912 Lincoln av., PomptonLakes(16)
McCullough, John H, 523 E. State st., Trenton (11)
McCullough, Walter A., Essex Co. Hosp.,CedarGr.(7)
McDede, Frank F., 922 Main st., Paterson (16)
McDede, J. Searle, 215 Ege av., Jersey City (9)
McDermott, Vincent T., 511 State st., Camden (4)
McDonald, Frank R., 79 Summit av., Jersey City (9)
McDonald, Richard J., 294 Broadway, Paterson (16)
McDonnel, Gerald E., 41 Cherry st., Mt. Holly (3)
McDonnell, Geo. J., 80 W. Main st., Freehold (13)
*McElhinney, D. R., Elizabeth (20)
McElroy, Ervin, 20 Main st., Rockaway (14)
McFeeley, P. Ralph, 242 Palisade av., Bogota (2)
McGeehan, Stanley M., 100 S. Maryl'd av., At. C'y(1)
McGinn, Wm. J., 1913 Westfield av., Scotch Pl. (20)
McGlade, Thos. H., 2953 Yorkship Sq., Camden (4)
McGovern, John F., Jr., 24Liv'gst'n av.,N.Br'w'k(12)
McGuigan, Francis A., 212 N. Warren st.,Tr'nt'n(11)
McGuire, Jas J., 122 W. State st., Trenton (11)
McGuire, Jos. T., 77 Autumn st., Lodi (2)
McKelvie, Julius C., 55 Rockwell av., Long Br. (13)
McKiernan, Robt. L., 97 Bayard st., N. Bruns. (12)
McKim, Wm. F., 488 Sanford av, Newark (7)
McKinstry, John W., Railroad av., Jamesburg (12)
McLane, A. Donald, 498 Engle st., Englewood (2)
McLean, Herbert E., 92 Fairview av., Jersey C'y (9)
McLean, Hugh A., 414 17th st., West New York (9)
McLellan, Geo. A., 19 Hawthorne av, E.. Orange (7)
McLoughlin, Frank J., 558 Jersey av., Jer. City (9)
McMahon, Bernard C., 18 DeHart st., Morrist'n(14)

McMurray, Geo. B., N. J. St. Hosp., Gr'yst'nePk.(14)
*McNenney, Claudio E., 113 Fairview av., Jer.C'y(9)
McPherson, M. E., 141 DiamondBr.av.,H'wth'rne(16)
McTague, Robt. S.,9Memorial pkwy.,Atl.Highl'ds(13)
McVay, Edward A., 234 Lafayette st., Newark (7)
*Mead, Walter G., 699 Kearny av., Kearny (9)
Means, Paul B., State Hospital, Trenton (11)
Mears, Wm. G., 22 Overlook av., Leonia (2)
Mecray, Paul M., 405 Cooper st., Camden (4)
Medd, John C., 25 Curtis pl., Maplewood (7)
Meehan, Geo. E., 117 Mercer st., Jersey City (9)
Meehan, Martin M., 339 Washington av.,Belleville(7)
Meeker, Irving A., 581 Valley rd., Up. Montclair (7)
Meier, Wm. U., 1062 Ringwood av., Haskell (16)
Meigh, Josiah, Bernardsville (18)
Meineke, Wm., C., Jr., 820 Chestnut st., Roselle (20)
Meinzer, Martin S., 147 Market st., Perth Amb'y(12)
Mellen, Stanley H., 863 Mt. Prosp'ct av., Newark (7)
Meloney, Lester F., 156 Second st., Clifton (16)
Meltsner, Louis, 904 Hudson st., Hoboken (9)
Meltzer, Louis, 32 W. 33rd st., Bayonne (9)
Mendelsohn, David H., 576 Broadway, Paterson(16)
Mendelsohn, Lewis, 272 Montgomery st., Jer. C'y(9)
Mendenhall, Clinton D.,412F'rnsw'th av.,B'rd'nt'n(3)
Meneve, Alfred D., 87 Bridge st., Paterson (16)
Menge, Carl H., 213 Washington st., Toms River(15)
Mengel, Willard G., 400 Penn st., Camden (4)
Menk, Paul E., 31 Lincoln Park, Newark (7)
Meredino, Anthony G., 2720 Pacific av., Atl. City (1)
Merkelbach, W. P., 316 Broad st., Bloomfield (7)
Merliss, Eugene, 386 Clinton av., Newark (7)
Merlo, Francis A., 210 Murray st., Elizabeth (20)
Merrill, Chas. F., 16 S. 3rd av., Highland Park (12)
Merselis, John G., 110 Irvington av., So. Orange (7)
Mersheimer, Christian H., 15 Reserv'r av., J. C'y (9)
Metzer, Emma P. W., 430 Fairview st., Riverside(3)
Metzger, Karl F., 603 Ninth av., Belmar (13)
Meurlin, Alfred, 158 S. Harrison st., E. Orange (7)
MeVay, Jas. C. F., 2907 Pacific av., Atlantic City(1)
Meyer, Eugene A., Moorestown (3)
Meyer, Geo. P., 410 Haddon av., Camden (4)
Meyer, Howard M., 400 Maple Hill dr., Hackens'k (2)
Meyer, Wm., 436 New York av., Union City (9)
Meyers, Francis R., 627 E. 24th st., Paterson (16)
Meyerson, Noah, 428 15th st., West New York (9)
Mezzetti, Alfred F., 220 S. 6th st., Vineland (6)
Mial, Leonidas L., 38 Elm st., Morristown (14)
Michela, Luigi S., 206 Carroll st., Paterson (16)
Michell, Geo. E., 221 High st., Hackettstown (14)
Mick, Edwin C., 46 S. Burnett st., East Orange (7)
Mickewich, S. A., 650 Ave. C, Bayonne (9)
Miele, Frank A., 314 Carr av., Keansburg (13)
Mierau, Ernest W., 1096 Sanford av., Irvington (7)
Miller, Earle K., 2502 Nottingham wy, Trenton (11)
Miller, Gerald H., N. Main st., Cranbury (11)
Miller, H. Garrett, 203 E. Main st., Millville (6)
Miller, Herman, 786 S. 12th st., Newark (7)
Miller, Jos. A., 364 Prospect st., So. Orange (7)
Miller, Lewis H., 37 S. Main st., Woodstown (17)
Miller, Max H., 311 16th st., West New York (9)
Miller, Robt. M., 382 Springfield av., Summit (20)
Miller, Samuel R., 31 N. Main st., Pennington (11)
Miller, Samuel T., 1408 Grand av., Asbury Park (13)
Miller-Richardson, Emma, 577 Stevens st.,C'md'n(4)
Miller, Theodore R., 316 State st., Hackensack (2)
Milligan, Robt. S., 239 Morris av., Summit (20)
Mills, Alvah V., Lindsley rd., Little Falls (16)
Mills, Chas. S., 106 Lippincott av., Riverton (3)
Mills, Clifford, 36 Maple av., Morristown (14)
Mills, Stephen D., 132 S. Euclid av., Westfield (20)
Minard, E. L., 140 4th av., East Orange (7)
Miner, Donald, 96 Gifford av., Jersey City (9)
Minier, Carl L., 25 N. Harrison st., E. Orange (7)
Miningham, Wm. D., 18 Hedden ter., Newark (7)
Minnella, Thos. J., 132 Morris av., Summit (20)
Mintz, Abraham, 94 Shanley av., Newark (7)
Mishell, Daniel R., 730 Prospect st., Maplewood (7)
Mitchell, Augustus J., 59 South st., Newark (7)
Mitchell, Chas. H., 1100 W. State st., Trenton (11)
Mitchell, Chas. R., 311 Broadway, Paterson (16)
Mitskas, Theodore V.J.,704Greenwood av.,Tr'nt'n(11)
Mockett Walter W., 714 P'lis'de av., Cliffside P'k(2)
Mockridge, Oscar A., 8 S. Mountain av., Montcl'r(7)
Moeckel, Clarence W., 63 S. Fullert'n av.,M'ntcl'r(7)
Moffat, Barclay W., Nut Swamp rd., Red Bank (13)
Mohrbacher, John J., 37 Osborne ter., Newark (7)
Moister, Roger W., 7 Norwood av., Summit (20)
Molitch, Matthew, State Home for Boys,J'm'sb'g(12)
Montfort, Robt. J., 1051 E. Jersey st., Elizabeth (20)
Moore, Frank F., 201 Evergreen av., Woodlynne(4)
Moore, John D., 6 Washington st., Bloomfield (7)
Moore, Ralph L., 127 N. Broad st., Woodbury (8)
Moran, Helen C., 151 Engle st., Englewood (2)
Moress, Edward J., 1551 Maple av., Hillside (20)
Moretti, John J., 576 S. Clinton av., East Orange (7)
Morgan, Browne, 32 Benson st., Bloomfield (7)
Moriconi, Albert F., 438 Hamilton av., Trenton (11)
Morley, Grace C., 2787 Blvd., Jersey City (9)
Morill, Jas. P., 310 Broadway, Paterson (16)
Morris, Carlyle, Spring st. & Lake av., Metuch'n(12)
Morris, Clement, 511 Broadway, Newark (7)
Morris, David G., 11 W. 26th st., Bayonne (9)
Morris, Thos. M., 505 Park av., Plainfield (20)
Morris, Watson B., 193 Morris av., Springfield (20)
Morrison, Caldwell, 379 7th av., Newark (7)
Morrison, Frederick H., Newton (19)
Morrison, J. Bennett, 66 Milford av., Newark (7)
Morrone, John A., 233 Bowers st., Jersey City (9)
Morrow, Jos. R., Bergen Pines Hosp. ,Ridgewood (2)
Moschkowitz, Hermann, 737 High st., Newark (7)
Moscoe, Harry A., Main st., Lincoln Park (16)
Motzenbecker, Peter F., 680 High st., Newark (7)
Moulton, Chas. D., 122 Park av., East Orange (7)
Mount, Walter B., 21 Plymouth st., Montclair (7)
Mras, John M., 977 S. Broad st., Trenton (11)
Mueller, Geo. H., 102 Summit av., Jersey City (9)
Muldoon, Edward J., Florence (3)
Mulford, Ephraim R., 100 E. Broad st., Burl'gt'n(3)
Muller, Fredk. L., 413 Third st., Carlstadt (2)
Mulligan, Luke A., 230 Central av., Leonia (2)
Mullin, Raymond J., 857 S. 11th st., Newark (7)
Mulvihill, Wm. J., 275 Hudson blvd., Bayonne (9)
Munger, Ray T., 727 Watchung av., Plainfield (20)
Munro, Chas. A., Marlton (3)
Munro, Jeannette, 293 Nassau st., Princeton (11)
Murn, Chas. J., 48 Smith st., Paterson (16)
Murphy, Chas. M., 21 Main st., Farmingdale (13)
Murphy, Edward A., 1 Britton st., Jersey City (9)
Murphy, Herschel S., 320 Chestnut st., Roselle (20)
Murphy, Jas. A., 467 Hamilton av., Trenton (11)
Murphy, Jas. M., 2757 Boulevard, Jersey City (9)
Murphy, Leo J., 374 West st., Union City (9)
Murphy, Patrick H. W., 27 Jefferson av., Jer. C'y(9)
Murray, Edwin W., 558 Newton av., Camden (4)
Murray, Harrold A., 624 Mt. Prospect av.,Newark(7)
Murray, Jos. A., 765 Ave. C, Bayonne (9)
Murray, Norman L., 129 Summit av., Summit (20)
Murto, Thos. V., 532 W. State st., Trenton (11)
Musetto, Carmelo A., 135 Cornelia st., Boonton (14)
Mustermann, Otto H., 303 48th st., Union City (9)
Muta, Samuel A., 47 Park av., West Orange (7)
Muttart, Geo. W., 702 Ocean av., Jersey City (9)
Mutter, Alfred A., 75 Beech st., Arlington (9)
Myatt, Leslie E., 98 N. Pearl st., Bridgeton (6)
Myers, Norman V., 301 Knickerbocker rd.,Tenafly(2)

ASSOCIATE MEMBERS

Macaluso, Dominic C., 7 Hilton st., Belleville (7)
MacArt, Jas. H., 74 S. Munn av., East Orange (7)
Mackin, John J., 596 Bergen av., Jersey City (9)

Magee, Harold S., N. J. State Hospital, Trenton (11)
Mann, Benjamin, 468 Brace av., Perth Amboy (12)
Marcus, Donald, 640 Stuyvesant av., Irvington (7)
Margaretten, Edw. I., 262 High st., Perth Amboy(12)
Margolis, Boris, 28 West End av., Newark (7)
Mason, V. A., 100 Chestnut st., E. Orange (9)
Matturri, Dominick A., 174 Clinton av., Jer. City (9)
McCarron, James A., 341 Ave. A, Bayonne (9)
McCarthy, Cornelius P., 327 Blvd., Bayonne (9)
McIntyre, Harold E., 144 Harrison st., E. Orange(7)
Miller, Chas. W., Jr., N. J. State Hosp., Tr'nt'n (11)
Miller, Ralph, 55 Wilbur av., Newark (7)
Mullin, Eugene P., 515 Sanford av., Newark (7)

ACTIVE MEMBERS

Nacca, Carl A., 86 N. Essex av., Orange (7)
Nafey, Herbert W., 51 Livingston av., N. Bruns.(12)
Nagler, Benedict, 75 Shephard av., Newark (7)
Naidorff, Saul A., 404 W. 7th st., Plainfield (20)
Nalitt, David I., 28 W. 33rd st., Bayonne (9)
Nappi, Pasquale E., 250 Mt. Prospect av.,Newark(7)
Nash, Alexander E., 30 Forest av., Verona (7)
Nash, Herman S., 865 S. 11th st., Newark (7)
Nataro, Joseph, 172 Littleton av., Newark (7)
Naulty, Chas. W., 403 High st., Perth Amboy (12)
Neal, Chas. B., Pine & Third sts., Millville (6)
Neer, Wm., 245 Broadway, Paterson (16)
Neiderhoffer, Sydney L., 469 Broadway, LongBr.(13)
Nelson, Harry, 36 Lupton st., Woodbury (8)
Nemirow, Martin, 234 Lexington av., Passaic (16)
Nemzek, Wm. P., 141 Ridge rd., N. Arlington (7)
Nesbitt, Eliz., No. Jer. Training Sch'l,LittleFalls(16)
Netz, Lester W., 414 Main st., Hackensack (2)
Neville, Robt. J., 547 Main st., Hackensack (2)
*Nevin, John, Kensington av., Jersey City (9)
Nevius, Wm. B., 61 N. Arlington av., E. Orange (7)
Newcomb, Marcus W., Browns Mills (3)
Newman, Abraham J., 70 Sherman pl., Jer. C'y (9)
Newman, Grace T., 339 Grove st., Montclair (7)
Newman, Louis G., 316 E. Broad st., Westfield (20)
Nichols, Stanley, 501 Grand av., Asbury Park (13)
Nicholson, Frank P., 895 Summit av., Jer. City (9)
Nickman, E. Harrison, 101 S. Newton av., At.C'y(1)
Nicol, Lorenz C., 360 Larch av., Bogota (2)
Nicoll, Geo. L., 48 W. Blackwell st., Dover (14)
*Niemeyer, Frank V., 4610 Blvd., Union City (9)
Niemtzow, Frank, 45 E. Main st., Freehold (13)
Nimaroff, Meyer, 265 Union av., Irvington (7)
Nittoli, Rocco M., 660 E. Jersey st., Elizabeth (20)
Noll, Louis, 1383 Clinton av., Irvington (7)
Nonziato, Frank A., 50 Centre st., Trenton (11)
North, Harry R., 160 W. State st., Trenton (11)
Norton, Jas. F., 299 Varick st., Jersey City (9)
Norval, Wm. A., 419 Main st., Paterson (16)
Notkin, Meyer, 351 Van Houten st., Paterson (16)
Novello, Jos. A., 641 Second av., Elizabeth (20)
Nuse, Edward F., 550½ Jersey av., Jersey City (9)
Nye, Howard H., 174 Carroll st., Paterson (16)
Nyiri, Wm. A., 30 Van Ness pl., Newark (7)

ASSOCIATE MEMBERS

Nadel, Charles L., 1186 Clinton av., Irvington (7)

ACTIVE MEMBERS

Obert, Josiah E., Main st., New Egypt (15)
Obester, Gabriel E., 646 Madison av., Elizabeth (20)
O'Brian, Dennis M., 154 Lexington av., Passaic (16)
O'Brian, Jeremiah H., 204 Madison st., Passaic (16)
O'Brien, Paul, 196 Main st., East Rutherford (2)
Ockene, Abraham, 494 Palisade av., Union City (9)
O'Connor, Bernard A., 47 Central av., Newark (7)
O'Connor, J. J., 434 New York av., Union City (9)
O'Connor, Michael J., 98 Shanley av., Newark (7)
O'Crowley, Clarence R., 31 Lincoln Park, New'rk(7)
Oderr, Chas., 121 S. Euclid av., Westfield (20)
Oestmann, August W., 932 Summit av., Jer. C'y (9)
O'Gorman, Michael W., 880 Bergen av., JerseyC'y(9)
O'Hanlon, Geo., Medical Center, Jersey City (9)
Okin, Irving, 165 Passaic av., Passaic (16)
Older, Benj., 435 New York av., Union City (9)
Oleynick, S. A., 107 Clinton av., Newark (7)
Olini, Jos. J., 30 W. Market st., Newark (7)
Oliver, David H., 188 E. Commerce st., Bridgeton(6)
Olpp, Arch. E., 316 Bergenline av., Union City (9)
O'Mara, John A., 314 St. Clair av., Spring Lake (13)
O'Neill, Chas. L., 11 N. 7th st., Newark (7)
O'Neill, John H., 270 Montgomery st., Jersey City(9)
*Opdyke, Chas. P., 10 Summit rd., Verona (7)
Opdyke, Gordon M., 52 Claremont av., Verona (7)
Opdyke, Levings A., 55 Clinton av., Jersey City (9)
Openchowski, Mieczyslaw, 324 Parker st., Newark(7)
Oram, Jos. H., 495 Broadway, Paterson (16)
Oren, Hyman, Park av., Park Ridge (2)
Orloff, Samuel, 149 Lyons av., Newark (7)
Ornaf, Ignace E., 1145 Thurman st., Camden (4)
O'Rourke, Jas. J., 871 Stuyvesant av., Trenton (11)
Ortolano, Jas. J., 159 First st., Hoboken (9)
Orton, Carlton B., 321 E. 2nd av., Roselle (20)
Orton, Geo. L., 98 Elm av., Rahway (20)
Orton, Henry B., 24 Commerce st., Newark (7)
Osborn, Adam D., 519 Sixth av., Belmar (13)
O'Shea, John J., 135 Shippen st., Weehawken (9)
Osher, Morris M., 194 Martine av., N. Fanwood (20)
Oshrin, Henry, 750 Park av., West New York (9)
Osmun, Milton M., 611 Broadway, Camden (4)
O'Sullivan, John R., 284 Chestnut st., Kearny (9)
Ovens, Ritchie C., 675 Bergen av., Jersey City (9)
Owen, Logan S., 938 Hudson st., Hoboken (9)

ASSOCIATE MEMBERS

O'Grady, Michael J., 299 Broadway, Newark (7)
Opitz, R. Burton, 218 Brindle way, Palisade (2)

ACTIVE MEMBERS

Pacicco, Michele, 376 Monmouth st., Jersey City (9)
Paddock, Royce, 965 Broad st., Newark (7)
Pagano, Peter, 45 N. Broad st., Ridgewood (2)
Pagliughi, John J., 401 18th st., Union City (9)
Pal, Darbari R., 32 Clark st., Paterson (16)
Pallen, Conde deS., 6 Passaic st., Rochelle Park (2)
Palm, Howard F., 614 N. 2nd st., Camden (4)
Palmer, Francis R., 249 Lexington av., Passaic (16)
Palmer, Gideon H., 28 Winans st., East Orange (7)
Palmer, Henry S., 275 Mulberry st., Newark (7)
Panigrosso, Louis R.,284Washington st.,P.Amb'y(12)
Panitch, Wm., 356 Belmont av., Newark (7)
Pannell, Walter L., 25 Prospect st., E. Orange (7)
Pannullo, John N., 266 Van Buren st., Newark (7)
Pantaleone, Jos., 504 Hamilton av., Trenton (11)
Parent, Sol., 924 S. 20th st., Newark (7)
Parisi, Anthony, 296 S. Orange av., Newark (7)
Parker, H. Norton, 72 N. Clinton av., Trenton (11)
Parker, Jas. W., 175 Shrewsbury av., Red Bank (13)
Parker, John E., 144 S. Harrison st., East Orange(7)
Parrk, M. Benjamin, 360 Park av., Paterson (16)
Parry, Oliver K., 601 Bangs av., Asbury Park (13)
Parsonnet, Eugene V., 31 Lincoln Park, Newark (7)
Pascall, Thos. M., 197 Lincoln av., Newark (7)
Paschal, Geo. W., Jr., 96 N. Main st., Milltown (12)
Patella, Fulvio, 232 Broadway, Paterson (16)
Patterson, Isaac N., 230 Broadway, Westville (8)
Patti, Frank A., 340 Broad st., Leonia (2)
Paul, Geo. A., 788 Lyons av., Irvington (7)
Paul, H. Carl, 24 Hanford pl., Caldwell (7)
Paulson, Archibald M., 160 E. 7th st., Plainfield (20)
*Payawall, J. L., Ramsey (2)

Payne, Guy, Overbrook Hospital, Cedar Grove (7)
Payne, Jos., 223 Godwin av., Midland Park (2)
Peacock, Arthur B., Columbus (3)
Pearl, Sydney S., 545 Rahway av., Elizabeth (20)
Pearlman, Saul J., 210 Lexington av., Passaic (16)
Pearlstein, Frank, 325 16th st., West New York (9)
Pedevill, Jos. R., 232 Highland av., Palisades P'k(2)
Pedrick, Wm. W., 11 West st., Glassboro (8)
Peer, Lyndon A., 965 Broad st., Newark (7)
Pegau, Paul M., 246 Briar Hill lane, Woodbury (8)
Pellarin, John D., 493 New York av., Union City(9)
Pellet, Thos. L., Hamburg (19)
Pellicane, Anthony J., 191 Sandford st.,N.Bruns.(12)
Pelusio, August N., 269 Carroll st., Paterson (16)
Penchansky, Samuel, 847 Ave. C, Bayonne (9)
Pendexter, Sidney E., 11 S. Arlington av., E. Or.(7)
Pennington, A. W., 398 N. Maple av., Newark (7)
Pennington, John, 101 S. Indiana av., Atlantic C'y(1)
Pentel, Louis S., 307 16th st., West New York (9)
Perham, Bertram S., 199 Lorraine av., Up. M'tcl'r(7)
Perham, Roy G., 248 Boulevard, Hasbr'k Hgts.(2)
Perkel, Louis L., 2801 Hudson blvd., Jersey City (9)
Perlberg, Harry J., 921 Bergen av., Jersey City (9)
Pernetti, Anthony M., 715 Broadway, Paterson (16)
Perrine, Cornelius C., 500 River rd., Red Bank (13)
Perrotta, Anthony J., 94 Maple av., Red Bank (13)
Perry, Frank L., 43 East av., Woodstown (17)
Pessel, Johannes F., 224 W. State st., Trenton (11)
Peters, Richard C., 963 Park av., Plainfield (20)
Peterson, Chas. A., 921 Washington st., Hoboken (9)
Peterson, Walter R., 312 W. State st., Trenton (11)
Petry, Wm., 109 Treacy av., Newark (7)
Pettit, Harry H., 138 Franklin av., Ridgewood (2)
Pettit, Herschel, 807 Wesley av., Ocean City (5)
Phelan, Walter F., 124 Chilton st., Elizabeth (20)
Phelps, Jas. E., 203 Park av., Paterson (16)
Phillips, Algernon A., 13 Howard st., Newark (7)
Phillips, Claude B., 891 Haddon av., Collingsw'd (4)
Phillips, Robt. H. C., 144 W. State st., Trenton (11)
Phillips, Walter, 109 E. Palisade av., Englewood (2)
Pieper, Howard C., 426 Bath av., Long Branch (13)
Pierson, Carl L., 178 W. State st., Trenton (11)
Pierson, Jos. R., Hopewell (11)
Pigott, Albert W., Skillman (18)
Pike, Chas. E., 411 Newton av., Oaklyn (4)
Pilch, Arthur G., 1 Willard av., Bloomfield (7)
Pilkington, Albert, 117 S. Virginia av., Atl. City (1)
Pilloni, Louis, 91 Beach st., Bloomfield (7)
Piltz, Geo. F., 153 25th st., Guttenberg (9)
Pinckney, Frank H., 186 South st., Morristown (14)
Pindar, Arthur W., 627 Queen Anne rd., Teaneck (2)
Pindar, Fredk. S., 960 Park av., N. Bergen (9)
Pindar, I. C. D., 627 Queen Anne rd., Teaneck (2)
Pinerman, R. B., 269 Bordentown av., S. Amboy (12)
Pingitore, Eufelia, 412 Main st., Hackensack (2)
Pinkerton, Wm. A., 854 Ave. C, Bayonne (9)
Pinneo, F. W., 439 Mt. Prospect av., Newark (7)
Pino, Anthony, 196 Irving av., Bridgeton (6)
Pinsky, Mordecai M., 944 S. 5th st., Camden (4)
Piskorski, Abdon V., 604 Jersey av., Jersey City (9)
Pitkin, G. P., 4 S. Washington av., Bergenfield (2)
Pizzi, Francis W., 205 Park av., Orange (7)
Plain, Irving H., 2 Stratford pl., Newark (7)
Plant, James S., 502 High st., Newark (7)
Plante, Amos. A., 437 Ridgewood rd., Maplewood (7)
Platt, Thos. H., 307 N. Washington st., Dunellen (12)
Plavin, Nathan J., 5460 Hudson Blvd., N. Bergen (9)
Plinke, Fritz, 159 Lexington av., Passaic (16)
Plume, Clarence A., Succasunna (14)
Podell, Alexander A., 51 E. Front st., Red Bank (13)
Pogoloff, Samuel H., Manville (18)
Pois, John, 52 Pillot pl., W. Orange (7)
Polakoff, Joseph, Main st., Stirling (14)
Poland, Geo. A., 206 E. Verona av., Pleasantv'le (1)
*Poland, Joseph, Atlantic City (1)
Poleshuck, Rubin, 127 Hollywood av., Hillside (20)
Polizzotti, Joseph L., 193 Park av., Paterson (16)
Polk, Chas. C., 114 E. 7th av., Roselle (20)
Pollak, B. S., Hud. Co. Tub. San., Jersey City (9)
*Polevski, Jacob, 682 High st., Newark (7)
Pollis, Nicholas L., 642 High st., Newark (7)
Polow, Benjamin, 24 Johnson av., Newark (7)
Polowe, David, 558 E. 27th st., Paterson (16)
Pomeranz, Raphael, 31 Lincoln Park, Newark (7)
Pons, Carlos A., 501 Grand av., Asbury Park (13)
Potter, Benj. P., Hud. Co. Tub. San., Jersey City (9)
Potter, Ellen C., 301 W. State st., Trenton (11)
Potter, Raymond T., 144 Harrison st., E. Orange (7)
Pottinger, W. E., Midvale rd., Mountain Lakes (14)
Povalski, Alex. W., 1925 Boulevard, Jersey City (9)
Powis, Ethel M., 198 W. State st., Trenton (11)
Poyas, Morton L., 1871 Pennington rd., Trenton (11)
Prager, Bert A., 251 Main st., Chatham (14)
Prather, Chas. G., 260 Westwood av., Westwood (2)
Prather, John W., 155 Washington av., Dumont (2)
Pratt, Arthur G., 516 Cooper st., Camden (4)
Pratt, Wm. H., 516 Cooper st., Camden (4)
Pregnall, J. P., 501 Grand av., Asbury Park (13)
Prestifilippo, S., 61 Ardsley st., Montclair (7)
Preston, Perry B., 12 Palm st., Newark (7)
Price, Chas. W., Essex Co. Hosp., Cedar Grove (7)
Price, Nathaniel G., 31 Lincoln Park, Newark (7)
Prigger, Edw. R., 39 W. Main st., Pennsgrove (17)
Prince, Robert A., 567 Broadway, Paterson (16)
Principato, Roberto, 402 Walnut st., Camden (4)
*Pringle, F. A., N. Fullerton st., Montclair (7)
Probst, E. W., 19 Hasbrouck pl., Rutherford (2)
Proctor, F. E., 1245 Greenwood av., Trenton (11)
Proctor, Jas. W., 188 Engle st., Tenafly (2)
Proctor, Jessie E., 15 N. 13th st., Newark (7)
Prout, Thomas P., 19 Prospect st., Summit (20)
Prout, Wm. B., 88 W. Forrest av., W. Englewood (2)
Pudney, Wm. K., 31 Trinity pl., Montclair (7)
Pullen, Guy F., 111 Leonia av., Leonia (2)
Purcell, Ernest F., 800 Stuyvesant av., Trenton (11)
Purdy, Chas. H., 35 Highland av., Jersey City (9)
Pursell, Wm. D., 508 S. Main st., Phillipsburg (21)
Pyle, Louis A., 89 Fairview av., Jersey City (9)
Pyle, Wallace, 15 Exchange pl., Jersey City (9)

ASSOCIATE MEMBERS

Pattyson, R. A., 144 Harrison st., East Orange (7)
Payne, Guy, Jr., 9 Prospect st., Verona (7)
Policastro, N. C., 378 Union st., Hackensack (2)
Pudney, B., 139 Montgomery st., Jersey City (9)

ACTIVE MEMBERS

Quad, Clifford W., 52 Northfield av., W. Orange (7)
Quigley, Frederic J., 4622 Blvd., Union City (9)
Quinby, Wm. O'G., 14 James st., Newark (7)
Quinn, John J., 921 Bergen av., Jersey City (9)
Quinn, Norman J., 3303 Pacific av., Atl. City (1)
Quinn, Stephen T., 326 S. Broad st., Elizabeth (20)
Quirk, Martin A., 90 W. Front st., Red Bank (13)

ACTIVE MEMBERS

Raab, Michael, 111 Lexington av., Passaic (16)
Rader-Hoheb, K. A., 5 Lincoln av., Rutherford (2)
Radest, Louis J., 158 Hamilton av., Paterson (16)
Rado, William, 190 Clinton av., Newark (7)
Rados, Andrew, 31 Lincoln Park, Newark (7)
Ragany, Joseph, 966 S. Broad st., Trenton (11)
Rainey, Willard G., 34 Bayard lane, Princeton (11)
*Ramos, Nicholas I., 188 Market st., Newark (7)
Ramsey, F. Muriel, 310 E. Pine st., Millville (6)
Randall, Chas. H., 50 Third av., Newark (7)
*Randolph, John M., Main st., Rahway (20)
Ranson, Bris. B., 144 S. Harrison st., E. Orange (7)

Rapp, Robert F., 302 S. Main st., Hightstown (11)
Rathgeber, Chas. F., 18 William st., E. Orange (7)
*Rathgeber, Wm. M., 249 Roseville av., Newark (7)
Raughley, Wm. C., Taunton av., Berlin (4)
Rauschenbach, Paul E., 225 Broadway, Paterson (16)
Ravitz, Samuel F., 1143 Broad st., Newark (7)
Rawitz, Sidney B., 42 Chancellor av., Newark (7)
Ray, Erwin L., Newark Airport, Newark (7)
Read, H. S., 5407 Atlantic av., Ventnor (1)
Read. Jessie D., 519 Lenox av., Westfield (20)
Read, Wm. T., Jr., 429 Cooper st., Camden (4)
Reale, N. P., Weiss Bldg., S. Main st., Manville (18)
Rector, Joseph M., 681 Bergen av., Jersey City (9)
Reed, F. Grendon, 144 Harrison st., E. Orange (7)
Reeves, Ernest, 195 Lexington av., Passaic (16)
Reeves, John F., 55 East av., Bridgeton (6)
Reich, Abraham, L., 83 Lyons av., Newark (7)
Reich, Henry, 31 Lincoln Park, Newark (7)
Reich, Jerome J., 1410 Maple av., Hillside (20)
Reich, Samuel B., 348 Kinderkamack rd., Oradell (2)
Reid, Erwin W., 125 Marcellus pl., Garfield (2)
Reilly, James J., 622 Penn st., Camden (4)
Reilly, John V., 472 Sanford av., Newark (7)
Reiner, Jacob, 811 N. Broad st., Elizabeth (20)
Reinfeld, Abraham G., 354 Clinton av., Newark (7)
Reingold, Alexander, 221 Garden st., Hoboken (9)
Reinhold, H. E., 441 W. Engl'w'd av., W. Engl'w'd (2)
Reisinger, Paul B., 369 W. State st., Trenton (11)
Reissman, Erwin, 31 Lincoln Park, Newark (7)
Reitter, G. S., 144 Harrison st., E. Orange (7)
Reitnaur, John S., 518 44th st., Union City (9)
Relyea, Geo. McD., 129 Summit av., Summit (20)
Remer, Daniel F., 417 High st., Mount Holly (3)
Renner, Dan S., State Village, Skillman (18)
Renzulli, Francesco, 228 S. 7th st., Newark (7)
RePass, Paul E., 144 Harrison st., E. Orange (7)
Rettig, Isidor L., 36 Milford av., Newark (7)
Reyner, D. C., 2703 Pacific av., Atlantic City (1)
Reynolds, Earle C., 655 Main av., Passaic (16)
Reynolds, G. G., 64 W. Main st., Freehold (13)
Reynolds, Harry C., 657 Main av., Passaic (16)
Rhoads, S. Creadick, 104 Station av., Westville (8)
Rhone, David S., 1202 Haddon av., Camden (4)
Ribbans, Robert C., 63 Central av., Newark (7)
Rice, Franklin W., 184 South st., Morristown (16)
Rich, Charles, 191 Littleton av., Newark (7)
Richards, Paul S., 1 Main st., Butler (16)
Richardson, A. H., 60 Orange rd., Montclair (7)
Richardson, Chas. A., Main st., Closter (2)
Richie, Emory W., 172 James st., Hackensack (2)
Rieck, Allan, 507 S. Shore rd., Pleasantville (1)
Rieck, Walter R., 139 Pleasant pl., Kearny (9)
Rieman, A. P., 3566 Boulevard, Jersey City (9)
Riese, J. A., 636 Palisade av., West New York (9)
Riggins, E. N., 161 No. Arlington av., E. Orange (7)
Rineberg, I. E., 94 Bayard st., New Brunswick (12)
Rinzler, H. G., 127 Van Houten av., Passaic (16)
Riordon, John 110 Maple st., Rutherford (2)
Ripley, C. D., Curtis av., Point Pleasant Beach (7)
Ripley, Edward W., 7 Trinity pl., Montclair (7)
Ripps, Maurice L., 410 Elmora av., Elizabeth (20)
Ristine, Edwin R., 123 Maple av., Westville (4)
Rizzolo, Edward M., 523 Union av., Belleville (7)
Robbin, Lewis, 18 Clinton pl. Newark (7)
Robbins, Chas. M., 31 Lincoln Park, Newark (7)
Robbins, Henry B., 144 Mercer st., Jersey City (9)
Robbins, Warren D., 202 Ocean av., Cape May (5)
Roberts, Allison H., 24 S. 9th st., Newark (7)
Roberts, David C., 158 S. Harrison st., E. Orange (7)
Roberts, E. W., 760 Palisade av., W. New York (9)
Roberts, Frank A., 11 Park av., Caldwell (7)
Roberts, Jos. E., Jr., 403 Cooper st., Camden (4)
Roberts, William A., 11 Park av., Caldwell (7)
Robertson. Grace M., 650 W. 7th st., Plainfield (20)
Robinson, Ernest A., 149 Atkins av., Asbury Pk. (13)
Robinson, J. T., 598 Watchung av., Bound Brook (18)
Robinson, Louis H., 31 Lincoln Park, Newark (7)
Robinson, Silas E., Franklin Turnpike, Waldwick (2)
Robinson, Wm. A., 62 Main av., Ocean Grove (13)
Rocco, Frank, 729 Summer av., Newark (7)
Rodman, Ellwood W., 503 Cooper st., Beverly (3)
Roeber, Wm. J., 21 Nesbit ter., Irvington (7)
Roemer, Jacob, 213 Broadway, Paterson (16)
Rogers, Alvin S., 233 N. Warren st., Trenton (11)
Rogers, Dorothy M., 50 Cooper st., Woodbury (8)
Rogers, Edw. B., 814 Haddon av., Collingswood (4)
Rogers, Harry, 144 Harrison st., E. Orange (7)
Rogers, Harry L., 408 Main st., Riverton (3)
Rogers, Laurence H., Municipal Col., Trenton (11)
Rogers, Richard M., 1 Wallace st., Newark (7)
Rogers, Robert H., 49 9th av., Newark (7)
Roh, Robert F., 671 Broad st., Newark (7)
Romano, Anthony M., 134 Broadway, Hillsdale (2)
Rona, Maurice, 159 Bayard st., N. Brunswick (12)
Roop, W. O., 101 S. Indiana av., Atlantic City (1)
Rosamilia, Ralph E., 480 N. 7th st., Newark (7)
Rose, Mary D., 453 Park av., Orange (7)
*Roth, Robert F., 41 Haddon av., Westmont (4)
Rosecrans, James H., 826 Hudson st., Hoboken (9)
Rosenberg, Jacob, 692 Bergen av., Jersey City (9)
Rosenberg, Louis, 26 S. Stenton pl., Atl. City (1)
Rosenberg, L. Chas., 11 Murray st., Newark (7)
Rosenblatt, Sidney, 1904 Pacific av., Atl. City (1)
Rosenstein, Jacob L., 568 Bergen av., Jer. City (9)
Rosenstein, S. L., 2120 Springfield av., Vauxhall (20)
Ross, Alexander S., 542 Cooper st., Camden (4)
Rossell, Edward W., 801 Cooper st., Camden (4)
Rossi, Bartolomeo, 60 Park av., Madison (14)
Roth, Oswald H., 210 Littleton av., Newark (9)
Rothenberg, Samuel, 31 Lincoln Park, Newark (7)
Rothhouse, Burnet, 19 Lincoln Park, Newark (7)
Rothman, Benj. G., 21 Main st., Sussex (19)
Rothman, Theodore, 268 Park av., Paterson (16)
Rothschild, Daniel L., 585 Elizabeth av., Newark (7)
Rothschild, K., 149 Livingston av., N. Brunsw'k (12)
Rothseid, Abraham, 59 Avon av., Newark (7)
Rothstein, Isadore B., 16 Lyons av., Newark (7)
Rowan, Henry M., 224 W. State st., Trenton (11)
Rowe, Joseph A., 247 Franklin av., Ridgewood (2)
Rowe, Norman L., 828 Grand st., Jersey City (9)
Rowland, James J., 321 Bay av., Highlands (13)
Rowland, John H., 159 New st., N. Brunswick (12)
Roy, Bert W., Sussex (19)
Rube, Joseph A., 145 Prospect st., Ridgewood (2)
Rubin, A. A., 379 Washington av., Belleville (7)
Rubinow, Saul M., 755 High st., Newark (7)
Rucker, Wm. C., 408 Main st., Hackensack (2)
Ruffu, Henry L., 111 S. Boston av., Atlantic City (1)
Rullman, Walter A., 58 W. Front st., Red Bank (13)
Rundlett, E. V., 79 Prospect st., Jersey City (9)
Runnells, J. E., Bonnie Burn San., Scotch Pl'ns (20)
Runyan, Wm. J., 106 Broad st., Bloomfield (7)
Runyon, L. P., 80 Somerset st., N. Brunswick (12)
Ruocco, William B., 416 River st., Paterson (16)
Ruoff, Andrew C., 494 New York av., Union City (9)
Russell, David L., 690 Bergen av., Jersey City (9)
Russomanno, R. L., 227 Clifton av., Newark (7)
Ruttenberg, Louis, Union st., Mantua (8)
Ruttenberg, Max, 303 Cooper st., Camden (4)
Ruvane, Jos. J., 38 Bentley av., Jersey City (9)
Ryan, John N., 158 Lexington av., Passaic (16)
Ryan, Joseph J., 55 Fairmount av., Chatham (14)
Ryley, Harold W., 1 Lincoln pl., E. Rutherford (2)
Ryman, Merlin T., 4 N. Hillside av., Chatham (14)

ASSOCIATE MEMBERS

Rampona, Joseph M., 118 Nassau st., Princeton (11)
Randazzo, A. P., 82 Prospect st., Passaic (16)
Reading, H. E., 538 E. 29th st., Paterson (16)
Reinhardt, W. I., 296 N. Arlington av., E. Orange (7)

Rita, James J., 235 S. Clinton av., Trenton (11)
Robertson, E. S., 22 Harding ter., Kearny (7)
Roles, E. W., 25 N. Harrison st., East Orange (7)
Romano, P. J., 203 S. Sussex av., Orange (7)
Rosen, Chas. D., 27 Clonavor rd., W. Orange (7)
Rubino, Nicholas M., 67 N. 4th st., Newark (7)

ACTIVE MEMBERS

Sacco, A. G., 440 New York av., Union City (9)
Sacco, Gregory E., 191 Broad st., Red Bank (13)
Sachs, Wilbert, 921 Bergen av., Jersey City (9)
Sadoff, Joseph, 116 Elmora av., Elizabeth (20)
Salasin, Samuel L., 511 Pacific av., Atlantic City (1)
*Salmon, Edward H., 669 Bergen av., Jersey City (9)
Salmon, E. F., Hud. Co. Con. Dis. H., Secaucus (9)
Salmon, Kurt, 732 Lyons av., Irvington (7)
Salvati, Leo H., 275 Orchard st., Westfield (20)
Salway, Benjamin, 321 S. Broad st., Trenton (11)
Salzman, Nathan, 714 Broadway, Paterson (16)
Samson, Norman D., 281 Kearny av., Kearny (7)
Samuel, Jerome H., 31 Lincoln Park, Newark (7)
Samuels, S. L., 612 W. Front st., Plainfield (20)
Sandella, Joseph F., 169 New st., N. Brunswick (12)
Sandler, Samuel A., 65 Tonnele av., Jersey City (9)
Sands, Ord L., 501 Grand av., Asbury Park (13)
Sanfacon, Thomas A., 340 Park av., Paterson (16)
Santangelo, Emil L., 400 Broadway, Paterson (16)
Santangelo, Stephen, 304 Varick st., Jer. City (9)
Saradarian, A. V., 481 New York av., Union City (9)
Saslow, Benj., 680 Clinton av., Newark (7)
Sasso, Albert, 99 Parker st., Newark (7)
Satchwell, Harry H., 169 Roseville av., Newark (7)
Satulsky, Emanuel M., 544 Jersey av., Elizabeth (20)
Saunders, Orris W., 1700 Broadway, Camden (4)
Sawyer, Blackwell, Washington st., Toms River (15)
Sax, Max T., 84 Grove st., Bloomfield (7)
Sayre, Wm. D., 69 Maple av., Red Bank (13)
Sbarra, F. C., 531 W. Market st., Newark (7)
Scammell, Frank G., 40 S. Clinton av., Trenton (11)
Scanlan, D. Ward, 15 S. Illinois av., Atl. City (1)
Scasserra, B. B., 163 Nassau st., Princeton (11)
Schaaf, Royal A., 413 Mt. Prospect av., Newark (7)
Schaefer, Eugene P., 12 Harrison pl., Irvington (7)
Schaffer, N., 172 S. Arlington av., E. Orange (7)
Schall, R. Elmer, 537 N. 7th st., Camden (4)
Schapiro, Joseph, 712 Palisade av., Union City (9)
Schectman, Vera, 385 Osborne ter., Newark (7)
Scheffler, Wilhelm A., 511 Cooper st., Camden (4)
Schellenger, Edward A., 429 Cooper st., Camden (4)
Schept, Samuel S., 523 37th st., Union City (9)
Scher, Maurice A., 137 Lyons av., Newark (7)
Schildkraut, J. M., 170 W. State st., Trenton (11)
Schiller, Nicholas, 29 Girard pl., Newark (7)
Schilling, A. B., 727 Jefferson av., Elizabeth (20)
Schimmelpfennig, R. D., 65 N. Fullerton st., M'tcl'r(7)
Schisler, M. M., Second & Church sts., Florence (3)
Schlein, August, 707 Park av., Hoboken (9)
Schlein, David, 26 Price st. E., Linden (20)
Schlichter, C. H., 556 N. Broad st., Elizabeth (20)
Schlossbach, T., 94 S. Main st., Ocean Grove (13)
Schmidt, Albert F., 81 Union av., Manasquan (13)
*Schmidt, Mathias, Denville (14)
Schmidt, W. W., 386 Palisade av., Cliffside Pk. (2)
Schmukler, Jacob, 29 Rutgers st., Maplewood (7)
Schneckendorf, S. J., 179 Harrison av., Jer. City (9)
Schneider, Chas A., 694 Clinton av., Newark (7)
Schneider, Louis, 874 S. 13th st., Newark (7)
Schneider, L. A., 412 17th st., West New York (9)
Schoenau, C. W., 1255 Broad st., Bloomfield (7)
Schrack, Helen F., 216 N. 5th st., Camden (4)
Schramm, Joseph A., 23 Darcy st., Newark (7)
Schreck, Harry, 192 Roseville av., Newark (7)
Schroeder, Henry J., 110 W. State st., Trenton (11)
Schuchner, W. F., 550½ Jersey av., Jersey City (9)
Schuck, Traugott J., 58 9th st., Hoboken (9)
Schulman, A. S., 4638 Boulevard, Union City (9)
Schulman, Robt., Aurora Inst., Morristown (14)
Schulsinger, Samuel, 80 Clinton av., Newark (7)
Schulte, Herbert A., 701 Clinton av., Newark (7)
Schults, Anna R., 207 Summer av., Newark (7)
Schultz, A. M., 379 Union av., Paterson (16)
Schurman, Francis H., 14 Smull av., Caldwell (7)
Schwartz, Henry C., Raritan av., Atco (4)
Schwartz, Samuel H., 300 W. 7th st., Plainfield (20)
Schwartz, William, 155 Lexington av., Passaic (16)
Schwarz, B. T., 2787 Hudson Blvd., Jersey City (9)
Schwarz, H. J., 5560 Hudson Blvd., N. Bergen (9)
Schwarzkopf, G. C., 2901 Pacific av., Atl. City (1)
Schweizer, Roman G., 36 Summit rd., Elizabeth (20)
Sciorsci, E. F., 609 Bloomfield st., Hoboken (9)
Scott, Elmer A., Belle Mead San., Belle Mead (13)
Scott, Frederick J., Franklin (19)
Scott, F. W., 102 Bayard st., New Brunswick (12)
Scott, Harold R., 10 Speedwell av., Morristown (14)
Scott, Karl M., 1616 Pacific av., Atlantic City (1)
Scott, Parry M., 466 Cooper st., Beverly (3)
Scott, R. Hunter, 205 Roseville av., Newark (7)
Scott, Samuel G., 141 Bergen av., Jersey City (9)
Scranton, C. W., 59 Washington st., E. Orange (7)
Scribner, C. H., R.F.D. No. 1, H'g T'pike,Paters'n(16)
Scruggs, W. J., 3005 Kearsage rd., Camden (4)
Scudder, F. D., 65 N. Fullerton av., Montclair (7)
Scullion, A. A., 460 Anderson av., Cliffside Pk. (2)
Sealey, Henry J., 79 Washington av., Dumont (2)
Seely, Roy B., 78 N. Clinton av., Trenton (11)
Segard, Christian P., 204 Glenwood av., Leonia (2)
Seid lman, Sidney E., 1919 Greenw'd av.,Trenton(11)
S idler, Victor B., 16 Plymouth st., Montclair (7)
*Seidler, Wm. F., Rosemere pl., Belleville (7)
Seidman, E. A., 580 High st., Newark (7)
Seifert, Edwin A., 247 Claremont av., Montclair (7)
Seitzick-Robbins, H. E., 733 H'milt'n av., Tr'nt'n(11)
Sekerak, Albert J., 984 S. Broad st., Trenton (11)
Selinger, Samuel, 413 16th st., West New York (9)
Sell, Frederick W., 167 W. Emerson av.,Rahway(20)
Sellers, Robert R., 19 Chestnut st., Newark (7)
Sender, Fannie, 123 Main st., South River (12)
Senerchia, Fred F., Jr., 604 Westminst'r av.,Eliz.(20)
Sewall, Millard F., 195 E. Commerce st.,Bridgeton(6)
Seward, F. H., 40 Green Village rd., Madison (14)
Sewell, Stephen, 212 Jersey av, Spring Lake (13)
Sexsmith, George H., 719 Ave. C, Bayonne (9)
Sexton, Edward V., 176 Edgemont ter., Teaneck (2)
Seybold, Arthur D., 302 E. 7th st., Plainfield (20)
Seymour, Edward T., 55 Hillside av., Tenafly (2)
Sferra, Alfred F., 125 Hamilton st., Bound Br'k (18)
Shack, Maxwell H., 226 Morris av., Springfield (20)
Shafer, Albert H., 405 Cooper st., Camden (4)
Shafer, Fred'k W., 634 Penn. av., Camden (4)
Shangle, Milton A., 34 Prince st., Elizabeth (20)
Shanik, Wm., 415 Sunset av., Asbury Park (13)
Shannon, Anne L., 66 S. Fullerton av., Montcl'r (7)
Shannon, Jas. B., 66 S. Fullerton av., Montclair (7)
Shapiro, Chas. S., Maple Shade (3)
Shapiro, Louis, 146 Broad st., Newark (7)
Shapiro, Louis G., 375 Broadway, Paterson (16)
Shapiro, Maurice, 750 Ave. C, Bayonne (9)
Shapiro, Nathaniel J., 192 Palisade av., Union C'y(9)
Sharp, Chas. E., Port Norris (6)
Sharp, Jennie S., 719 Cooper st., Camden (4)
Sharp, Reuben L., 719 Cooper st., Camden (4)
Shaul, Frederick G., 10 Washington st., Bl'mf'ld (7)
Shaw, Ernest B., 811 Collings av., W. Col'gsw'd (4)
*Shaw, Jos. B., 119 S. Warren st., Trenton (11)
Sheaffer, C. P., 241 Kings Hgwy. E., Haddonf'd (4)
Sheehan, Daniel C., 12 Cliff st., Newark (7)
Sheeran, Vincent J., 269 Jewett av., Jersey City (9)
Sheets, C. C., 213 W. Broad st., Paulsboro (8)
Shemeley, Wm. G., 7 Haddon av., Camden (4)

Shenfeld, Isaac, 4806 Atlantic av., Atlantic City (1)
Shepard, Myron, 435 16th st., West New York (9)
Sheppard, A. G., 309 Broad st., Elmer (6)
Sheppard, Frank R., 131 N. 3rd st., Millville (6)
Sheppard, Muse A., 102 Main st., Elmer (6)
Sheppard, R. L., 768 N. 27th st., Camden (4)
Sherk, A. Lincoln, 2647 Westfield av., Camden (4)
Sherman, A. Russell, 671 Broad st., Newark (7)
Sherman, Allton L., 485 Park av., Orange (7)
Sherman, Arthur E., 25 Prospect st., E. Orange (7)
Sherman, Benj., Aurora Institute, Morristown (14)
Sherman, Byron G., 52 Maple av., Morristown (14)
Sherman, Elbert S., 671 Broad st., Newark (7)
Sherman, Fuller G., 53 Newton av., Woodbury (8)
Sherman, Samuel H., 81 Elmora av., Elizabeth (20)
Sherman, Wm. E., 88 Schureman st., NewBruns.(12)
Shill, Benj., 135 Johnson av., Newark (7)
Shimer, A. Burton, 606 Pacific av., Atlantic City (1)
Shimer, Floyd A., 88 Lewis st., Phillipsburg (21)
Shipman, James S., 542 Cooper st., Camden (4)
Shippee, David N., 648 Ringwood av., Wanaque (16)
Shippee, James N., 648 Ringwood av., Wanaque (16)
Shipps, Hammell P., 739 Chestnut st., Delanco (3)
Shirlock Margt. E., Vinel'd St. Sch'l, Vineland (18)
Shirrefs, Russell A., 348 Elmora av., Elizabeth (20)
Shivers, Chas. H., 121 S. Illinois av., Atlantic C'y(1)
Shope, Edward P., 511 Cooper st., Camden (4)
Shor, David M., 32 So. Munn av., East Orange (7)
Shore, Ernest L., 306 Atlantic av., Atlantic City (1)
Shull, Elliott C., 517 Cooper st., Camden (4)
Shull, John V., 84 Market st., Perth Amboy (12)
Shulman, Abraham, 528 E. 29th st., Paterson (16)
Shulman, Nathan L., 538 45th st., Union City (9)
Sica, L. Samuel, 431 E. State st., Trenton (11)
Sickel, Emanuel M., 220 Madison av., Lakewood(15)
Sieber, Isaac G., 204 Merchant st., Audubon (4)
Siegel, Jacob W., 96 S. 10th st., Newark (7)
Siegel, Sidney L., 227 N. Second st., Millville (9)
Siegler, Julius, 646 Bergen av., Jersey City (9)
Silk, Chas. I., 278 High st., Perth Amboy (12)
Sill, John B., 1129 Hamilton av., Trenton (11)
Silver, E. Drew, 136 Stockton st., Hightstown (11)
Silver, Geo. A., 242 Stockton st., Hightstown (11)
Silver, Harry B., 190 Clinton av., Newark (7)
Silvers, Homer I., 16 S. Suffolk av., Ventnor (1)
Silverstein, Benj. J., 32 Hillside av., Newark (7)
Silverstein, Max, 605 First av., Asbury Park (13)
Simeone, Peter A., 555 38th st., Union City (9)
Simkins, Raymond, 117 Broad st., Bridgeton (6)
Simmons, Albert V., 720 Prospect st., Maplewood (7)
Simms, Geo. F., 541 Page st., Lyndhurst (7)
Simon, Henry, 5 Vermont av., Newark (7)
Simon, Ludwig L., 201 Ferry st., Newark (7)
Simon, Morris L., 174 Washington pl., Passaic (16)
Sinexon, Henry L., 36 W. Broad st., Paulsboro (8)
Singer, Bella, 406 Elmora av., Elizabeth (20)
Singer, Max, 147 Johnson av., Newark (7)
Singer, Sina S., 3443 Boulevard, Jersey City (9)
Sinkinson, Chas., 1616 Pacific av., Atlantic City (1)
Sinton, John Y., Imlaystown (11)
Sirott, Barnett H., 413 State st., Perth Amboy (12)
Sisson, Nelson W., 144 Harrison st., E. Orange (7)
*Sista, Charles R., 476 Hamilton av., Trenton (11)
Siveke, John, 106 Lexington av., Passaic (16)
Skinner, William F., Washington (21)
Skvarla, John A., 17 Koster st., Wallington (2)
Skwirsky, Joseph, 170 Hawthorne av., Newark (7)
Slack, Clarence J., 230 W. State st., Trenton (11)
Slaff, Florence, 16 Grove st., Passaic (16)
Slavin, Paul, 31 Lincoln Park, Newark (7)
Sloan, Samuel L., 182 Belmont av., Paterson (16)
Slobodien, Benj. F., 107 Market st., PerthAmboy(12)
Slocum, Harry B., Bath & Westw'd avs., L'g Br.(13)
Sly, John L., 382 Springfield av., Summit (20)
Smaine, Enrique del C., 549 Monroe st., Carlstadt(2)
Small, E. Lester, 30 Branch st., Medford (3)
Smalley, Mahlon C., Gladstone (18)
Smalley, Sara D., 530 Clifton av., Newark (7)
Smalzried, Elmer W., 69 Woodland av., E. Or. (7)
Smith, A. L. M., 62 Bayard st., New Brunsw'k (12)
Smith, Alexander L., 2672 Boulevard, Jersey C'y (9)
Smith, Andrew M., 344 Philadelphia av,EggH'rb'r(1)
Smith, Arthur B., 585 Bergen av., Jersey City (9)
Smith, Byron J., 851 S. Orange av., E. Orange (7)
Smith, Ellis L., Soho Hospital, Belleville (7)
Smith, Elroy W., 655 Main av., Passaic (16)
Smith, George H., 136 Evergreen pl., E. Orange (7)
Smith, Harold W., 179 Lincoln av., Orange (7)
Smith, Henry G., Essex Co. Hosp., Cedar Grove (7)
Smith, Houghton C., 1063 S. Clinton av., Trenton(11)
Smith, Ivan B., 400 W. Blackwell st., Dover (14)
Smith, James D., 701 N. 6th st., Camden (4)
Smith, John V., 463 State st., Perth Amboy (12)
Smith, Jos. J., 325 13th av., Newark (7)
Smith, Leon A., 655 Main av., Passaic (16)
Smith, Malcolm K., 22 Madison av., Morristown (14)
Smith, Thayer A., Short Hills (7)
Smith, Warren H., 91 Main st., Newton (19)
Smith, Wilbur A., 2 E. Clinton av., Oaklyn (4)
Smith, William H., 34 W. State st., Trenton (11)
Snavely, Earl H., City Hospital, Newark (7)
Snedecor, Spencer T., 50 Anderson st., Hackens'k (2)
Snyder, John E., 1023 Garden st., Hoboken (9)
Snyder, Wm. J., 74 Columbia ter., Weehawken (9)
Sobin, Julius, 24 Waverly av., Newark (7)
Somers, Fred L., 144 Harrison st., East Orange (7)
Sommer, Geo. N. J., 120 W. State st., Trenton (11)
Sommer, Geo. N. J., Jr., 120 W. State st., Tr'nt'n(11)
Sooy, Leslie T., 202 W. Holly av., Pitman (8)
Spalding, Henry J., 512 45th st., Union City (9)
Spano, Frank, 320 47th st., Union City (9)
Spath, George B., 722 Hudson st., Hoboken (9)
Spence, Henry, 2540 Hudson Blvd., Jersey City (9)
Spencer, Alvan, 395 W. Blackwell st., Dover (14)
Spencer, Ira T., 152 Main st., Woodbridge (12)
Spencer, James H., Jr., 23 Hospital rd., Franklin(19)
Spickers, Wm., 6 Church st., Paterson (16)
Spiegelglass, Abraham B., 417 Main st., Hack'ns'k(2)
Spillane, Timothy H., 379 S. Main st., Phillipsb'g(21)
Spivack, David, 944 E. Jersey st., Elizabeth (20)
Spradley, Jeems B., State Hospital, Trenton (11)
Sprague, Edward W., 86 Washington st., Newark(7)
Sprague, Seth B., 301 York st., Jersey City (9)
Spritzer, Thos. T., 21 Schuyler st., N. Brunsw'k (12)
Spurgeon, Dorsett L., 19 Church st., Newton (19)
Squires, Chas. A., 602 Central av., Plainfield (20)
Staehle, Richard H., 34 Lyons av., Newark (7)
Stage, Earl D., 11 James st., Morristown (14)
Stahl, Alfred, 55 Lincoln Park, Newark (7)
Stahl, Charles, 659 Sanford av., Newark (7)
Stalberg, Samuel, 3822 Ventnor av., Atlantic C'y (1)
Stamps, Geo. R., 214 E. Verona av., Pleasantv"le(1)
Stanton, Nathaniel B., 734 Park av., Plainfield (20)
Stark, Jacob, 645 Broadway, Paterson (16)
*Steadman, E. T., 107 Christopher st., Montclair (7)
Steel, Wm. A., Beesley Point (5)
Steele, Stephen, 10 W. Gibbons st., Linden (20)
Steffens, Chas. T., 307 N. Wash'gt'n av., Dunel'n(12)
Stein, Emil, 607 Park av., Elizabeth (20)
Stein, Geo. H., 406 Elmora av., Elizabeth (20)
Stein, Harry M., 227 W. Broadway, Paterson (16)
Stein, Isadore, 210 Elizabeth av., Elizabeth (20)
Stein, Jacob M., 68 Columbia ter., Weehawken (9)
Stein, Jos. M., 956 Newton av., Camden (4)
Stein, Louis A., 226 W. State st., Trenton (11)
Stein, Martin H., 163 Second st., Elizabeth (20)
Stein, Wm., 73 Livingston av., New Brunsw'k (12)
Steinberg, Benj. L., 534 Main st., Singac (16)
Steinbock, Fred'k W., 136 Garf'd av.,Avon-by-Sea(13)

Steiner, Edwin, 31 Lincoln Park, Newark (7)
Stephenson, Dan'l H., 213 Haddon av., Haddonf'd(4)
Stephenson, Gordon A., 145 Summit av., Summit(20)
*Stern, Arthur, 224 E. Jersey st., Elizabeth (20)
Stern, Samuel, 2815 Pacific av., Atlantic City (1)
Steuart, David F., 11 De Barry pl., Summit (20)
Stevens, J. Thompson, 55 Park st., Montclair (7)
Stevenson, Alex. M., 7506 Ventnor av., Margate (1)
Stevenson, Geo. S., W. Front st., Red Bank (13)
Stewart, Irving J., 529 Kings Hgwy., Swed'sb'ro(8)
Stewart, Robert G., 79 Midland av., Montclair (7)
Stewart, Sloan G., Pacific & N. C. avs., Atl. City (1)
Stewart, Walter B., 8 N. Tallahassee av., At.C'y(1)
Stickles, Lloyd C., 49 Parkhurst st., Newark (7)
Stiles, C. Campbell, 713 Park av., East Orange (7)
*Stillwell, Aaron, Somerville (18)
Stillwell, Harry C., 51 W. Milton av., Rahway (20)
Stimus, Howard G., 300 Kaighn av., Camden (4)
Stockfisch, Robt. H., 3644 Boulevard, Jersey City (9)
Stokes, Earle B., 144 Harrison st., East Orange (7)
Stokes, Jas. S., 85 Park av., Paterson (16)
Stokes, Joseph, 220 E. Main st., Moorestown (3)
Stokes, S. Emlen, 129 Chester av., Moorestown (3)
Stoltz, Raymond R., 23 Passaic av., Passaic (16)
Stone, Arthur L., 2838 Berkley st., Camden (4)
Stone, Robert G., State Hospital, Trenton (11)
Stone, Russell B., Phillipsburg (21)
Storaci, Frank S., 703 Hamilton av., Trenton (11)
Stout, John P., 165 Jewett av., Jersey City (9)
Strahan, F. G., 473 Broadway, Long Branch (13)
Strandberg, Herbert L., 94 W'sh'gt'n av., Cart'r't(12)
Straub, Herbert H., 242 Springdale av., E. Orange(7)
Straughn, Clinton C., 23 Monmouth st., Red B'k(13)
Strauss, Arthur, 130 Pavilion av., Long Branch (13)
Strauss, Clifton J., 911 Springf'd av.,N.Pr'vid'nce(20)
Street, Daniel B., 27 Woodlawn av., Jersey City (9)
Strelinger, Alexander, 689 Newark av., Elizab'h (20)
Strom, Abraham, 410 W. 7th st., Plainfield (20)
Stuart, Alexander A., 350 Main st., RidgefieldP'k(2)
Stuart, Wm. C., 518 Hudson st., Hoboken (9)
Subin, Harry, 1616 Pacific av., Atlantic City (1)
Sucoff, Moses C., 158 Hamilton av., Passaic (16)
Sullivan, Chas. J., 57 Paterson st., New Bruns. (12)
Sullivan, James A., 46 Bentley av., Jersey Ctiy (9)
Sullivan, Wm. M., Jr., 43 Passaic av., Passaic (16)
Sulouff, S. Henry, 622 Newark av., Jersey City (9)
Summerill, Garnett, 330 Cooper st., Camden (4)
Summerill, John M., Maple av., Pennsgrove (17)
Summers, Alfred D., 180 Nassau st., Princeton (11)
Summey, Thomas J., 175 Madison av., Mt. Holly (3)
Surnamer, Isaac, 345 Broadway, Paterson (16)
Surran, Carl A., 1616 Pacific av., Atlantic City (1)
Sussman, Harold, 326 24th st., Union City (9)
Suter, Harry F., 49 W. Main st., Pennsgrove (17)
Sutherland, William W., 320 Broadway,Paterson(16)
Sutnick, Theodore B., 801 So. Broad st., Trenton (11)
Sutton, Joseph G., Essex Co. Hosp., Cedar Gr. (7)
*Swan, Guy H., Beachwood (15)
*Swayze, A. A., 280 State st., Hackensack (2)
Sweeney, William J., 68 Clifton ter., Weehawken (9)
Swern, Nathan, 130 W. State st., Trenton (11)
Swertfeger, Herbert W., 106W.Broad st.,H'pew'l(11)
Swiecicki, Martin E., 317 Cl'm'nts Br. rd.,Bar'gt'n(4)
Swiney, Juliana C., 325 Ave. C, Bayonne (9)
Swiney, Merrill A., 325 Ave. C, Bayonne (9)
Symes, Earl R., 161 Kearny av., Kearny (7)
*Synott, Martin J., 63 Fullerton av., Montclair (7)
Szerlip, Leopold, 31 Lincoln Park, Newark (7)
Szold, Norman F., 603 Monmouth av., Lakew'd (15)
Szuch, Nicholas, 159 Main st., So. River (12)
Szymanski, John J., 616 Main av., Passaic (16)

ASSOCIATE MEMBERS

Sandler, S. A., 5 Pangborn pl., Hackensack (2)
Santoro, Thomas A., 272 S. 8th st., Newark (7)
Schaffer, Barney, 252 Washington av., Belleville (7)
Schneider, Clinton R., 125 N. Green st.,Tuckert'n(15)
Schotland, C. E., 41 Leslie st., Newark (7)
Seidman, Joshua I., 31 Lincoln Park, Newark (7)
Sellitto, A. M., 84 Hudson av., Maplewood (7)
Shaner, R. D., 94 Hillside av., Nutley (7)
Shaw, John J., 127 Sheerer av., Newark (7)
Shayevitz, A., 170 Main st., South River (12)
Shreehan, Hubert F., 382 Summer av., Newark (7)
Shulman, Murray W., 67 Myrtle av., Irvington (7)
Smith, Christopher A., 6 Park st., Roseland (7)
Smith, P. L., Dayton (12)
Spritzer, Theodore D., High Point Park (12)
Statman, Arthur J., 337 Hawthorne av., Newark (7)
Stone, Chas. T., 106 N. Monroe st., Ridgewood (2)
Strack, Vincent J., 286 Charlton av., So. Orange (7)
Suesserman, Henry, 389 Lyons av., Newark (7)
Sutton, Harold L., 44 Walnut st., Newark (7)

ACTIVE MEMBERS

Taber, Fred'k S., 49 Paterson st., New Bruns. (12)
Taber, Leslie R., 266 Van Houten st., Paterson (16)
Taft, Herman L., 25 Liberty pl., Weehawken (9)
Talmage, Wm. G., 389 W. Blackwell st., Dover (14)
Tansey, Wm. A., 98 Dover st., Newark (7)
Taranto, Michael, 635 N. Wood av., Linden (20)
Tarbell, Harold, 13 Pennington st., Newark (7)
Tataryan, Hovsep H., 422 New York av., Un.C'y(9)
Tatem, Henry R., Jr., Pine st. & Atl. av.,Audubon(4)
Tator, Arthur E., 57 DeForest av., Summit (20)
Taylor, Edward H., 3 Woodland rd., Maplewood (7)
Taylor, Geo. H., 590 Ridge av., Maplewood (7)
Taylor, Harold W., 247 Mountain rd., Englewood(2)
Taylor, Raymond A., 58 Madison av., Lakewood (15)
Taylor, Walter A., 450 Rutherford av., Trenton (11)
Teeter, Chas. E., 418 Orange st., Newark (7)
Teeter, John N., Lydecker st., Englewood (2)
Teimer, Theodor, 17 Hillside av., Newark (7)
Teller, Daniel W., Jr., 26 Maple av., Morristown (14)
Tellman, Daniel H., 120 Lexington av., Passaic (16)
Temes, Julius H., 293 Ege av., Jersey City (9)
*Tempesto, Jos. A., 306 Hamilton av., Trenton (11)
Temple, Arthur H., 164 Jefferson st., Passaic (16)
Tennis, Edgar M., 240 Engle st., Englewood (2)
Terhune, Percy H., 171 Paulison av., Passaic (16)
Terrell, Edward E., 110 Alden st., Cranford (20)
Terreri, D. Joseph, 30 High st., Morristown (14)
Teskey, Stanley, 10 Anderson rd., Bernardsville (14)
Tether, Russell K., Main st., Closter (2)
Thalheimer, Edward J., 644 Plum st., Vineland (6)
Thomas, F. A., Flemington (10)
Thomas, George N., 712 Wood st. V,ineland (6)
Thomas, John H., 270 Lenox av., So. Orange (7)
Thomas, Mary L., Village for Epileptics,Skillm'n(18)
Thomas, Ralph B., 793 Montgomery st., JerseyC'y(9)
Thomas, Thomas S., Jr., 26 Elm st., Morristown (14)
Thomison, Harry E., 605 Broad st., Newark (7)
Thompson, Arthur F., 144 Harrison st., E. Orange(7)
Thompson, Austin B., 479 Highland av., Orange (7)
Thompson, Penrose H., 4612 Westfield av., C'md'n(4)
Thompson, Theodore F., 316 First st., Lakewood(15)
Thomson, Carroll S., Fair Oaks San., Summit (7)
Thorne, Nathan, Moorestown (3)
Thorne, Wm. P., 254 Main st., Butler (16)
Thornhill, Arthur C., 47 Forest st., Montclair (7)
Thron, Leopold E., 586 E. 29th st., Paterson (16)
Tidaback, John D., 447 Springfield av., Summit (20)
Tidwell, Harold F., 229 16th st., West New York (9)

Tilles, Samuel, 44 Sheridan av., Seaside Hgts. (15)
Tillis, Herman H., 11 Bergen st., Newark (7)
Timberlake, Baxter H., 1616 Pacific av., Atl. City(1)
Timlin, James W., 64 Beech st., Arlington (9)
Tirrell, C. Malcolm, 725 High st., Newark (7)
Toal, Joseph, 803 Prospect av., Ridgefield (2)
Tobey, Franklin J., 11 Hazelwood av., Newark (7)
Todd, Francis H., 83 Auburn st., Paterson (16)
Tomasulo, Gennaro L., 225 Clifton av., Newark (7)
Tomec, Richard F., 42 Melrose pl., Montclair (7)
Tomkins, Wm., 105 Fairmount rd., Ridgewood (16)
Tomlin, H. Hurlburt, Magnolia & Atl.avs.,Wildw'd(5)
Tompkins, Grenelle B., Flemington (10)
Towbin, Adolph, 326 Third st., Lakewood (15)
Townsend, John B., 824 Wesley av., Ocean City (5)
Townsend, Leslie M., 37 Grant av. E., RoselleP'k(20)
Toy, Calvert R., 22 Kirkpatrick st., New Bruns. (12)
Toye, John E., 90 Midland av., Arlington (7)
Tracy, George T., Beverly (3)
Tracy-Dexter, Harriet E., 903 Ave. C, Bayonne (9)
Trautwein, C. F., 19 Treacy av., Newark (7)
*Traverso, Daniel, 703 D st., Belmar (13)
Treiber, Benj. A., 626 Perry st., Trenton (11)
Trippe, Clarence M., 702 Asbury av., Asbury P'k (13)
Trossbach, Herman, 97 Palisade av., Bogota (2)
Truax, Alfred J., 121 Church st., Boonton (14)
Tuers, George E., 418 Park av., Paterson (16)
Turi, Amedeo E., 57 Garside st., Newark (7)
Turner, Irvine F., 224 W. State st., Trenton (11)
Turner, Wm. F., 519 Magie st., Elizabeth (20)
Tushnet, Leonard, 662 18th av., Irvington (7)
Tutschulte, Ernest, 111 Mt. Pleasant av., Newark(7)
Tweddel, George K., 239 Broadway, Paterson (16)
Twitchell, Adelbert B., 162 So. Orange av., So. Or.(7)
Tymeson, Walter R., 310 Main st., Orange (7)
Tyndall, Alice E., 329 Mountain av. ,Westfield (20)
Tyndall, Martha W., 329 Mountain av., Westf'd (20)
Tyrrell, George W., 380 State st., Perth Amboy (12)
Tyson, Frances B., 101 Leonia av., Leonia (2)

ASSOCIATE MEMBERS

Tomec, Otto C., 407 W. State st., Trenton (11)
Torppey, John J., 124 Oakland ter., Newark (7)
Twinem, Francis P., 228 Anderson st., Hackens'k(2)

ACTIVE MEMBERS

Udinsky, Hyman J., 29 Passaic av., Passaic (16)
Uhr, Jacques S., 131 Livingston av., New Bruns.(12)
Ulan, Oscar, 170 Fleming av., Newark (7)
Ulmer, Chester I., 431 W. Broad st., Gibbstown (8)
Ulmer, David H., 199 Chestnut st., Moorestown (3)
Underwood, J. Harris, 509 N. Broad st., W'dbury(8)
Upham, Helen F., 305 Third av., Asbury Park (13)
Urbach, Geo., 173 Lafayette st., Newark (7)
Urbaniak, Henry S., 883 Brunswick av., Trenton(11)
Urbanski, Adrian X., 148 Market st., Perth Am.(12)
Urbanski, Matthew F., 314 W'sh'gt'n st.,P'thAm.(12)
Urevitz, Abraham, 495 New York av., Union City (9)
Uzzell, Edward F., 2703 Pacific av., Atlantic City (1)

ASSOCIATE MEMBERS

Ulverstad, L. E., 147 Halsted st., E. Orange (7)

ACTIVE MEMBERS

Vaccaro, S. P., 511 Third av., Asbury Park (13)
Vaczi, Stephen, 983 S. Broad st., Trenton (11)
Vail, Herbert B., 301 Washington av., Belleville (7)
Vail, James L., 28 Holly st., Cranford (20)
Vail, Wm. P., Blairstown (21)
Valentine, Edwin J., 2685 Blvd., Jersey City (9)
Vanderbeek, Andrew B., 174 Broadway, Paterson(16)
Vanderbeek, Andrew B., Jr., 456 Park av.,P'tr's'n(16)
Vanderbeek, Stuart W., 143 Engle st., Englew'd (2)
Vander Clock, Cornelius, 23 Passaic av., Passaic (16)
Vanderhoff, Irving M., 9 Clinton st., Newark (7)
Van der Veer, H. Garrett, 295M'tg'm'ry st.,Bl'mf'd(7)
Van Deusen, Edwin H., 12 N. 7th st., Vineland (6)
Van Duzer, Reeves B., 226 N. Park st., E. Orange(7)
Van Dyke, Benj. S., Cranbury (12)
Van Dyke, Joseph S., 42 W. PalisadeBlvd.,Pal.P'k(2)
Van Eerde, Albert, 339 Lafayette av.,Hawthorne(16)
Van Emburgh, Geo. H., 575 Belgrove dr., Arl'gt'n(7)
Van Gieson, Edward J., 70 Watsessing av.,Bl'mf'd(7)
Van Horn, Alfred F., 514 Central av., Plainfield (20)
Vannatta, Geo. W., 226 N. Park st., E. Orange (7)
Vanneman, Jos. S., 45 Princeton av., Princeton (11)
Van Ness, H. Roy, 444 Parker st., Newark (7)
Van Riper, Arthur W., 607 Main av., Passaic (16)
Van Schott, Gerard J., Jr., 245 Lex'gt'n av.,Pas'c(16)
Van Sciver, John E., 106 Broadway, Camden (4)
Van Sickle, Albert W., Chester (14)
Van Urk, Frederick T., 663 Main av., Passaic (16)
Van Winkle, Chas. I., 14 E. Park pl., Rutherf'd (2)
Van Winkle, John S., 297 Broadway, Paterson (16)
Varney, William H., 120 Belvidere av.,Wash'gt'n(21)
Varriano, John L., 3263 Boulevard, Jersey City (9)
Venturo, Ralph C., 101 S. Main st., Glassboro (8)
Verbeck, George B., 26 Washburn pl., Caldwell (7)
Villapiano, Jos. G., 701 Sunset av., Asbury Park (13)
Villegas, Juan A., 302 Day av., Fairview (2)
Vinciguerra, Michael, 604 Westminster av., Eliz.(20)
Visconti, Jos. A., 711 Garden st., Hoboken (9)
Vitale, Dominic V., 681 Newark av., Elizabeth (20)
Viteri, Luis E., 13 Brainerd st., Mt. Holly (3)
Vogel, Herbert A., 1060 E. Jersey st., Elizabeth (20)
von Deesten, Henry T., 268 Palisade av.,JerseyC'y(9)
VonHofe, Fred'k H., 75 Prospect st., E. Orange (7)
Voorhees, Florence E., 83 Lincoln Park, Newark (7)
Voorhees, W. S., Jr., Mendham (14)
Vosburgh, Fred., 61 Passaic av., Passaic (16)
Voss, Jack L., 21 Mt. Airy rd., Bernardsville (14)
Vostrosablin, Nicholas A., 121 Grand st., Jer. C'y(9)
Vreeland, Hamilton, 232 S. Irving st., Ridgewood (9)
Vreeland, Ralph D., 130 Woodland av., E. Orange(7)
Vreeland, Ralph J., 266 Van Houten st.,Paterson(16)
Vreeland, Wm. N., 32 Bergen av., Jersey City (9)
Vroom, Wm. L., 7 W. Ridgewood av., Ridgewood(2)

ASSOCIATE MEMBERS

Velluzzi, Joseph F., 311 Ave. C, Bayonne (9)

ACTIVE MEMBERS

Wacker, Wm. F., Jr., 1224 Salem av., Hillside (20)
Wagner, J. Geo., Delanco (3)
Wagner, Otto, 111 Stiles st., Elizabeth (20)
Wagner, Richard, 43 S. Broad st., Elizabeth (20)
Wainwright, F. P., 87 Bank st., Bridgeton (6)
Wakeley, Wm. E., 144 Harrison st., E. Orange (7)
Waldron, Edward L., 126 W. State st., Trenton (11)
Walker, Ada H., 635 Landis av., Vineland (6)
Walker, Harold G., Everett av., Wyckoff (16)
Walker, H. Burton, 635 Landis av., Vineland (6)
Walker, Levi M., 110 S. No. Carolina av., Atl. C'y(1)
Walker, Robert B., 108 Church st., New Bruns. (12)
Wallach, Bernard, 74 Watchung av., No.Plainf'd(18)
Wallack, Eli A., 333 Fairmount av., Jersey City (9)
Wallhauser, Henry J., 31 Lincoln Park, Newark (7)
Wallin, Alfred C., 166 Main st., Matawan (13)
Walscheid, Arthur J., 440 38th st., Union City (9)
Walsh, Chas. R., 21 W. Mt. Pl's'nt av., Liv'gst'n(7)
Walsh, Ronald J., 118 Fifth av. E., Roselle (20)
Walsh, Thomas J., 355 S. Broad st., Elizabeth (20)
Walsh, Thomas J., 514 Greenwood av., Trenton (11)
Walsh, Thomas M., 210 Kipp av., Hasbr'k Hgts.(2)
Walton, Gordon G., 17 Church st., Paterson (16)
Walton, Ralph W., 102 Gates av., Montclair (7)

Wambsgans, Magdalena, 44 Devine st., Newark (7)
Warburton, Jack C., 277 Broadway, Paterson (16)
Ward, Albert J., 39 Elm st., Morristown (14)
Ward, Alfred W., Main st., Closter (2)
Ward, Elizabeth B., 112 Chancellor av., Newark (7)
Ward, Geo. H., 240 Engle st., Englewood (2)
Ward, Gertrude, 41 Park pl., Bloomfield (7)
*Ward, John V., 438 Palisade av., Union City (9)
Ward, Leo J., 137 W. Jersey st., Elizabeth (20)
Ward, Lettie A., 325 Cooper st., Camden (4)
Ward, Wm. R., 112 Chancellor av., Newark (7)
Ware, Carl N., Shiloh (6)
Ware, Francis V., 223 N. Second st., Millville (6)
Warncke, Frank H., 523 Westfield av., Elizabeth(20)
Warner, Wm. H., 444 Central av., E. Orange (7)
Warren, Chas. B., 181 S. Prospect av., Bergenf'd (2)
Warren, David E., 265 Gregory av., Passaic (16)
Warren, Jacob, 308 18th av., Paterson (16)
Warter, Peter J., 626 W. State st., Trenton (11)
Warwick, Ralph A., 3300 Federal st., Camden (4)
Wassing, Hans, 695 Broadway, Paterson (16)
Waters, Chas. H., 928 W. State st., Trenton (11)
Waters, Edward G., 39 Gifford av., Jersey City (9)
Watkins, Geo. R., Warwick rd., Magnolia (4)
Watkins, Robert E., 517 5th av., Belmar (13)
Watman, Anthony J., 2761 Boulevard, JerseyCity(9)
Watov, Samuel E., 603 Beatty st., Trenton (11)
Watson, Fred'k S., 238 W. State st., Trenton (11)
Watson, Price T., 137 N. Main st., Milltown (12)
Watts, Wilbur, 436 E. State st., Trenton (11)
Way, Clarence W., Sea Isle City (5)
*Way, Eugene, Sea Isle City (5)
Way, Julius, Cape May Court House (5)
Wayman, Bernard R., 834Stuyvesant av.,Trent'n(11)
Webb, Wilson D., 316 State st., Hackensack (2)
Weber, Francis C., 286 Mt. Prospect av., Newark(7)
Weber, John F., 264 Main st., South Amboy (12)
Weber, Walter D., 305 23rd st., Union City (9)
Webner, C. Fred, 71 Lincoln Park, Newark (7)
Weeks, Norman E., 11 Seymour st., Montclair (7)
Weems, Don B., 105 E. Mantua av., Wenonah (8)
Wegryn, Louis S., 254 First av., Elizabeth (20)
Weigel, Chas. F., 328 E. Broadway, Salem (17)
Weigel, Edgar W., 970 Park av., Elizabeth (20)
Weigel, Elmer P., 727 Watchung av., Plainfield
Weimann, Max L., 803 Station av., Haddon Hgts.(4)
Weiner, Samuel E., 904 Pacific av., Atlantic City(1)
Weinert, Henry V., 128 Market st., Passaic (16)
Weinmann, Max H., 714 Scotland rd., Orange (7)
Weinstein, Morris W., 643 Chancellor av., Irv'gt'n(7)
Weinstock, Michael B., 13 Hillside av., Newark (7)
Weintraub, Wm. L., 400 Broadway, Paterson (16)
Weiss, Abram, 456 Palisade av., Weehawken (9)
Weiss, Louis, 849 S. 11th st., Newark (7)
Weiss, Morris J., 734 Ave. C, Bayonne (9)
Weiss, Selma, 2 Stratford pl., Newark (7)
Weissman, M. T., 727 Wood av., Linden (20)
Weithaase, Helen E., 803 Elmer st., Vineland (6)
Welcher, Howard A., 5436 HudsonBlvd.,No.B'rg'n(9)
Weller, Arthur, 19 Hillyer st., Orange (7)
Wells, Wm. C., Delanco (3)
Weres, James, Boulevard N., Alpha (21)
Werner, Erwin A., 2 S. Dwight pl., Englewood (2)
Wescott, Wm. C., Del. & Pacific avs., Atl. City (1)
West, Edgar L., 443 E. State st., Trenton (11)
West, Gordon F., 527 Penn st., Camden (4)
West, Guernsey F., 109 S. Main st., Phillipsb'g (21)
Westerhoff, Peter D., Highland av., Midland P'k(16)
Western, Frederic B., 1227 Morris av., Towley (20)
Westney, Alfred W., 3005 Pacific av., Atlantic C'y(1)
Wetterberg, Louis F., 389 School st.,Woodbridge(12)
Whaland, Berta, 117 Atlantic st., Bridgeton (6)
Wheatland, M. F., 727 Walnut st., Camden (4)
Wheeler, Jas. A., 85 Van Reypen st., Jersey City(9)
Wheeler, Wm. K., 31 Lincoln Park, Newark (7)
Whelan, Edward P., 460 Franklin av., Nutley (7)
Wherry, Elmer G., 325 Clinton av., Newark (7)
Whims, Clarence B., 5401 Ventnor av., Ventnor (1)
White, Frank S., 190 Carlton ter., Teaneck (2)
White, Harry J., Roosevelt Hosp., Metuchen (12)
White, R. Rostin, 644 Shore rd., Somers Point (1)
White, Robt. R., 25 S. Munn av., East Orange (7)
White, Thomas J., 50 Glenwood av., Jersey City (9)
Whiticar, John H., 767 Wesley av., Ocean City (5)
Whitken, Albert I., 2056 North av., Elizabeth (20)
Whitman, Lloyd B., 7 W. Clinton av., Bergenf'd(2)
Whittaker, Neil M., 418 Main st., Hackensack (2)
Wiant, Herman E., 120 Windsor av., Haddonfield(4)
Widetsky, Alfred, 69 Hamilton av., Paterson (2)
Wiener, Joseph, 601 Bangs av., Asbury Park (13)
Wiesler, Howard M., N.J. St.PrisonHosp.,Tr'nt'n(11)
Wikoff, J. Leslie, 799 Pennington av., Trenton (11)
Wilbur, Franklin L., 711 Grand av., Asbury P'k (13)
Wilbur, Wm. L., 156 Stockton st., Hightstown (11)
Wilcox, Frank A., 329 16th st., West New York (9)
Wild, Frederick A., 111 E. High st., Bound Br'k(18)
Wilentz, Wm. C., 188 Market st., Perth Amboy (12)
Wilkes, Arthur C., 36 Osborne ter., Newark (7)
Wilkes, LeRoy A., 143 E. State st., Trenton (11)
Wilkins, Stanley O., 41 E. Front st., Red Bank (13)
Wilkinson, Boyd E., 266 Van Houten st.,Paters'n(16)
Willan, Edward H., 74 S. Munn av., E. Orange (7)
Willard, Harry S., 266 Van Houten st., Paterson(16)
Willey, F. Parker, 5 Park st., Bloomfield (7)
Williams, Frank A., 324 W. Jersey st., Elizabeth(20)
Williams, Geo. W., 217 N. Warren st., Trenton (11)
Williams, Harry D., 527 E. State st., Trenton (11)
Williams, Hiram, 230 Lexington av., Passaic (16)
Williams, John J., 88 Walnut st., Newark (7)
Williams, Leonard D., 518 Park av., Plainfield (20)
Williams, Louis E., 20 Madison av., Madison (14)
Williams, R. A., Swarthmore & Atl. avs., Ventnor(1)
Williams, Wm. C., 9 Ridge rd., Rutherford (2)
Williamson, Wm. L., 22 W. 22nd st., Bayonne (9)
Willis, Benedict P., 23 Park av., Rutherford (2)
Willis, Herbert, Beach av. &Canter st.,B'chH'v'n(15)
Willis, John, 268 Palisade av., Jersey City (9)
Willner, Irving, 18 Waverly av., Newark (7)
Willson, James H., 144 Harrison st., E. Orange (7)
Wilner, Arthur A., 205 Market st., Trenton (11)
Wilson, Charles W., 636 Wood st., Vineland (6)
Wilson, Harrison B., 430 Union st., Hackensack (2)
Wilson, Herbert H., 24 Bank st., Bridgeton (6)
Wilson, J. E,. 110 Chapel av., Merchantville (4)
Wilson, Lawrence A., 114 N. Shore rd., Absecon (1)
Wilson, Robert B., 91 Broad st., Red Bank (13)
Wing, Raymond, Blair Hall, Blairstown (21)
Winn, Samuel L., Prof. Arts Bldg., Atlantic City (1)
Winslow, John H., 27 S. Valley av., Vineland (6)
Winter, Gladys C., 717 Norma ct., Teaneck (2)
Winters, Walter M., 288 Broadway, Paterson (16)
Wintsch, Carl H., 841 S. 12th st., Newark (7)
Wiren, Wm. E., 189 Ave. C, Bayonne (9)
Wise, Lester D., 119 Morris av., Long Branch (13)
Wishnack, Meyer, 318 Broadway, Paterson (16)
Witkoff, Ben., 190 Hackensack st., Wood Ridge (2)
Witmer, John D., 456 Middlesex av., Metuchen (12)
Witte, Chas. N., 711 Grove st., Point Pleasant (15)
Wittenborn, W. F. J., 1613 Brunsw'k av., Tr'nt'n(11)
Woelfle, Henry E., 907 Summit av., Jersey City (9)
Wolf, Frank A., 494 S. Main st., Phillipsburg (21)
Wolfe, Edward E., 1304 Teaneck rd., W. Englew'd(2)
Wolfe, Jacob S., 44 Watsessing av., Bloomfield (7)
Wolfe, James C., 56 Church st., Montclair (7)
Wolfe, William W., 383 Mulberry st., Newark (7)
Wolfson, Harry, 324 Broadway, Paterson (16)
Wolgin, Philip L., 445 Elmora av., Elizabeth (20)
Wolowitz, Harry B., 20 Spr'g Val. rd., Hackens'k(2)
Wood, Charles F., P. O. Box 195, Westfield (20)
Wood, E. LeRoy, 160 Roseville av., Newark (7)

Wood, Oran A., 128 W. Broad st., Paulsboro (8)
Woodruff, Dare, 630 Landis av., Vineland (6)
Woodruff, Ralph G., Main st., Englishtown (13)
Woodruff, Stanley R., 16 Enos pl., Jersey City (9)
Woody, McIver, 454 Union av., Elizabeth (20)
Woolf, Bernhardt H., 15 Hedden ter., Newark (7)
Worcester, George F., 220 Engle st., Englewood (2)
Woronoff, Murray, 120 Main st., Keyport (13)
Wort, Frederick J., 1080 Broad st., Newark (7)
Wrensch, Alexander E., 79 Valley rd., Montclair (7)
Wright, Herman W., 818 S. Broadway, Pitman (8)
Wright, Howard E., 173 Nassau st., Princeton (11)
Wright, Ralph S., 428 Richie av., W. Collingsw'd(4)
Wroblewski, B. M., 1166 Thurman st., Camden (4)
Wry, Dean A., 234 Dayton av., Clifton (16)
Wry, Orlin V., 95 High st., E. Rutherford (2)
Wyker, Arthur W., 229 Liberty st., Bloomfield (7)
Wyman, Edward H., 100 E. Broad st., Burlington(3)

ASSOCIATE MEMBERS

Waldron, R. E., 317 Roseville av., Newark (7)
Walters, G. M., 179 Main st., Woodbridge (12)
Waterman, S. M., 364 Clinton av., Newark (7)
Weinstein, Francis S., 189 16th av., Newark (7)
Witte, C. N., 1157 Brunswick av., Trenton (11)
Wolfe, R. E., 47 Lawrence av., West Orange (7)
Wright, R. E., 173 Park av., East Orange (7)

ACTIVE MEMBERS

Yachnin, Samuel C., 32 Ridge rd., Lyndhurst (16)
Yadowski, Emanuel, 637 High st., Newark (7)
Yaeger, Leslie A., 470 Hamilton av., Trenton (11)
Yager, Jacob A., 6 Church st., Paterson (16)
Yaguda, Asher, 88 Clinton av., Newark (7)
Yates, Glen, 330 Washington av., Belleville (7)
Yates, John S., 414 Ellison st., Paterson (16)
Zazujian, Dikran M., 562 E. State st., Trenton (11)
Yeaton, Wm. L., 204 11th st., Hoboken (9)
Yolken, Harry, 246 E. 31st st., Paterson (16)
York, James L., 331 River rd., New Milford (2)
Yood, Raphael L., 401 Grant av., Plainfield (20)
Yorke, Edward T., 516 N. Wood av., Linden (20)
Young, Franklin C., 120 Summit av., Summit (20)
Young, George J., 60 Maple av., Morristown (14)
Young, Irving H., 1203 Clinton av., Irvington (7)
Young, James L., 68 Mountain av., Somerville (18)
Yuckman, Robert O., 224 W. Jersey st., Elizab'th(20)
Yuckman, William, 224 W. Jersey st., Elizabeth (20)
Yudkoff, Wm., 403 Boulevard, Bayonne (9)

ASSOCIATE MEMBERS

Yates, Munford R., 199 Nassau st., Princeton (11)

ACTIVE MEMBERS

Zacchino, Arnold, 1156 Palisade av., Palisade (2)
Zalewski, Irene J., 125 Market st., Passaic (16)
Zandt, Frederic B., 16 Mercer st., Hamilton Sq. (11)
Zappala, John, 47 W. Main st., Pennsgrove (17)
Zehnder, A. Chas., 188 Roseville av., Newark (7)
Zeitlin, Herman H., 943 N. Wood av., Linden (20)
Zenneck, Junius F., 17 Fourth st., Weehawken (9)
Zentner, Maurice R., 1271 Hamilton av., Trenton(11)
Ziegler, Oscar F., 201 E. Pine av., Wildwood (5)
Zimmer, Wm., 83 Vassar av., Newark (7)
Zimmerman, Coler, 82 N. Arlington av., E. Or. (7)
Zimskind, Joshua N., 210 W. State st., Trenton (11)
Zitani, Alfred M., 937 Washington st., Hoboken (9)
Zuck, Arthur C., 22 Broad st., Washington (21)
Zuck, John A., Main st., Stanhope (19)
Zweibel, Leonard, 885 So. 13th st., Newark (7)
Zweigel, Isidore, 889 So. Orange av., E. Orange (7)

ASSOCIATE MEMBERS

Zybulzwski, E. A., 410 Bergen st., Newark (7)

OF MEDICINE
JUL 10 1937
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THE 171st ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

Held in Haddon Hall, Atlantic City, April 27, 28, and 29, 1937

THE OFFICIAL TRANSACTIONS

IN THREE PARTS

PART 1. MINUTES OF THE HOUSE OF DELEGATES---Pages 1-85

PART 2. REPORTS OF THE SCIENTIFIC FEATURES---Pages 86-93

PART 3. MINUTES OF THE WOMAN'S AUXILIARY---Pages 94-104

Issued as a Supplement to the Journal of The Medical Society of New Jersey, July, 1937

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PART ONE

MINUTES OF THE HOUSE OF DELEGATES

Tuesday Morning Session, April 27, 1937

The first session of the House of Delegates of the 171st Annual Meeting of The Medical Society of New Jersey convened in Haddon Hall, Atlantic City, New Jersey, at 10:40 o'clock on April 27, 1937, Dr. Spencer T. Snedecor, of Hackensack, President of the Society, presiding, and Dr. J. B. Morrison, Newark, Secretary.

1. Call to Order

President Snedecor: I now declare this one hundred and seventy-first session of the House of Delegates of The Medical Society of New Jersey officially opened.

2. Invocation

We will have the invocation by the Reverend George L. Whitmeyer of the All Saints' Episcopal Church of Atlantic City.

Rev. George L. Whitmeyer: Almighty God, Our Heavenly Father, who hast given us this good land of America as our heritage, grant that we may always be a people mindful of Thy favor and glad to do Thy will. Fill our land with honorable industry, sound learning, and pure manners. Save us from violence, discord, and confusion among ourselves, and fashion into one united people the multitude brought hither out of many kindreds and tongues. In the time of prosperity fill our hearts with thankfulness, and in the day of trouble suffer not our trust in Thee to fail. We also beseech Thee to direct the deliberations of this convention, with Thy most gracious favor and further them with Thy continual help, that all their works may be begun, continued, and ended as Thou wouldst have them. All this we ask in Thy Name. Amen.

3. Address of Welcome by Mayor W. F. Casey

President Snedecor: Our next order of business is an address of welcome by the Acting Mayor of Atlantic City, the Honorable William F. Casey. (Applause.)

The Honorable William F. Casey: It is a privilege, gentlemen, to represent His Honor, the Mayor. I happen to be one of the City Commissioners and I speak for all of them and all of the people of our city, when I extend to you a most cordial welcome. We are very, very proud to have such a distinguished group in our city as yourselves because, after all, it means so much to our community and it means so much to our State and our people.

We all hope and pray that in your scientific exhibition and deliberations you will be most successful because out of the success of your deliberations will come so much good for the rest of us humanity.

Gentlemen of the Convention, let me say that we of the officialdom of Atlanitc City want you to feel welcome, and we want you to have a pleasant stay in our city. If there is anything more we can do to make it more pleasant than it is now, let your wishes be known and we will serve you.

You have selected one of our best hotels. We are proud of this particular hotel, as we are proud of all our hotels; but this hotel, costing some $15,000,000, built for your comfort, for the comfort of those who come to our city, is practically a city self-contained, this one particular hotel, for it has every modern convenience known to a hotel building. Chalfonte-Haddon Hall is outstanding as a hotel in America, so we are proud that you have selected this hotel, because we have the feeling that in the corridors of the hotel each and every one of you will get to know each and every one that much better for having come here in convention.

There goes one privilege with those who receive conventions and that is to present to the presiding officer the official key of welcome, which I do with the greatest of pleasure, to Dr. Snedecor—our key. (Applause.)

President Snedecor: This is probably one of the finest keys presented by any city in the United States. Thank you, Mr. Commissioner! (Applause.)

4. Welcome to Haddon Hall

Now I should like to present Mr. Robert Leeds, of the Management of Haddon Hall. (Applause.)

Mr. Robert Leeds: Thank you, Mr. President!

Mr. President and Gentlemen: I consider it a privilege to be permitted to extend a greeting to the New Jersey Medical Society and to welcome you to Haddon Hall, where I hope you will all feel very much at home, and that I do now most heartily on behalf of our company and our entire staff. Our services and our facilities are at your command, and we shall endeavor to be always mindful of our own Hippocratic oath, if you will pardon the analogy, and to administer unto you with diligence and care.

To that end we have prepared a sort of shot-gun prescription, compounded of the good things of life, some genuine old-fashioned hospitality, food designed to whet even the most jaded appetites, and soft beds for refreshing sleep, in case you get around to it; soft sea air and warm sunshine. I regret, however, that our elixir has considerable precipitation and lacks the color of its usual appearance of sparkling wine; however, neither we nor the weather bureau, nor even the medical profession can circumvent acts of God, and I trust that you will overlook the temporary imperfection in our prescription, and that the stimulus of your meetings will compensate for the lack of sunshine at present, which I hope we will have before the day is over.

I thank you for this opportunity and I hope I may have it again next year. I wish you all the best of luck. (Applause.)

5. Reading of Minutes

President Snedecor: The next order of business, gentlemen, is the reading of the minutes of the last Annual Meeting. Since they were published as part of the transactions of the last Annual Meeting, I will entertain a motion that they be approved as published.

Secretary Morrison: I so move.

The motion was regularly seconded, was put to a vote, and was carried.

6. Welcome to Dr. J. B. Harrison

Secretary Morrison: Before we go any further, may I ask you to stand and give a hand to one of the oldest members of The Medical Society of New Jersey, who has never missed a meeting of the House of Delegates in sixty-two years, Dr. J. B. Harrison, of Union County. (Jour., May, p. 342.)

The assembly arose and applauded.

7. Greetings from the Atlantic County Medical Society

President Snedecor: Now, gentlemen, there is one more very important address of welcome to be given us by the President of the Atlantic County Medical Society, and I assure you that the Atlantic County Medical Society is a real host and glad to have us back in Atlantic City. I should like to recognize Dr. John S. Irvin, of Atlantic City. (Applause.)

Dr. John S. Irvin: My greetings will have the one virtue of being brief.

On behalf of the Atlantic County Medical Society, I take pleasure in welcoming you to Atlantic City.

After reading the Official Program, I am sure that your committees have done a good job and that the 171st Annual Meeting will surpass any that has been held in the past.

Although I have tried to read the reports of the officers and committees which are published in the latest issue of The Journal, I have succeeded in realizing only what a vast amount of constructive work these men have done. Much of this well be further developed at the sessions of this meeting.

Again I assure you that the Atlantic County Society is proud of the regularity with which you return to our city and promise you that we will always do our utmost to insure the success of these meetings. (Applause.)

President Snedecor: Thank you, Dr. Irvin.

8. Appointment of Reference Committees

It has been the custom for the past several years, in order to facilitate the business of this Society, to appoint a number of Reference Committees as special committees to which the various reports of committees can be referred. A few definite ones are specified by the By-Laws. The President has felt that it was important to appoint these reference committees before this meeting in order that they might consider carefully and completely the published reports. You will find a list of the Reference Committees in your Official Program (page 21) and in The Journal (April, p. 282), and is as follows:

(See also Sect. 21, containing corrections.)

Reference Committee "A" to consider reports of:
The President
Addresses of the President and President-Elect
The Executive Officer
The Finance and Budget Committee
The Treasurer

Edward W. Sprague, Chairman ..... Newark
George M. Knowles ..... Hackensack
Inglis F. Frost ..... Morristown
H. Burton Walker ..... Vineland
Samuel Salasin ..... Atlantic City
James P. Pregnall, Asbury Park, substituted for Dr. Frost. (Sect. 21.)
(Report, Sect. 74)

Reference Committee "B" to consider reports of:
The Secretary
The Board of Trustees
The Judicial Councilors
The Insurance Committee
The Advisory Committee to the Woman's Auxiliary
The Sub-Committee on Public Relations

Lancelot Ely, Chairman ..... Somerville
J. Howard Hornberger ..... Roebling
Reuben L. Sharp ..... Camden
Joseph W. Hurff ..... Newark
Harrison B. Wilson ..... Hackensack
(Report, Sect. 75)

Reference Committee "C" to consider reports of:
The Publication Committee
The Committee on Program and Arrangements
The Committee on Scientific Work
The Committee on Scientific Exhibits
The Welfare Committee
The Sub-Committee on Legislation

Edgar A. Ill, Chairman ..... Newark
Byron G. Sherman ..... Morristown
A. H. Coleman ..... Clinton
Henry Spence ..... Jersey City
Walter B. Mount ..... Montclair
(Report, Sect. 76)

Reference Committee "D" to consider reports of:
The Delegates to the A. M. A.
The Committee on Hospitals and Medical Education
The Board of Medical Examiners
The Committee on Honorary Membership
The Committee on Medical Defense

Leslie Myatt, Chairman ..... Bridgeton
Walter Rullman ..... Red Bank
William W. Pedrick ..... Glassboro
Runkle F. Hegeman ..... Somerville
Henry Haywood ..... New Brunswick
(Report, Sect. 77)

Reference Committee "E" to consider reports of:
The Sub-Committee on Public Health
and the Advisory Committees on:
Cancer Control
Child Health
Crippled Children
Maternal Welfare
Mental Hygiene
Tuberculosis
Venereal Disease Control

William H. Areson, Chairman .. Upper Montclair
Elwood E. Downs ..... Woodbury
Lorrimer B. Armstrong ..... Westfield
C. Byron Blaisdell ..... Long Branch
Charles H. Lyon ..... Phillipsburg
(Report, Sect. 78)

Reference Committee "F" to consider reports of:
The Sub-Committee on Medical Practice
and the Advisory Committees on:
Contract Practice
Hospital Relationships
Medical Care to Indigents
Nursing and Nursing Education
Pharmaceutical Problems
Workmen's Compensation

Herschel Murphy, Chairman ..... Roselle
J. Lawrence Evans ..... Woodcliff
Theodor Teimer ..... Newark
Clarence W. Way ..... Sea Isle City
David W. Green ..... Salem
(Report, Sect. 80)

SPECIAL REFERENCE COMMITTEES

I. Constitution and By-Laws

Samuel Alexander, Chairman .. Park Ridge
Wayne W. Hall ..... Paterson
Joseph M. Kuder ..... Mount Holly
Hugh H. Tyndall ..... Weehawken
Charles P. Bailey ..... Lakewood
Revised committee from Sections 14 and 15
Samuel Alexander ..... Park Ridge
S. Emlen Stokes ..... Morristown
Thomas B. Lee ..... Camden
E. L. Wood ..... Newark
Frank Scammell ..... Trenton
(Report, Sects. 14, 15, 17, 63, 68, 82)

II. Resolutions and Memorials

Watson B. Morris, Chairman ... Springfield
A. Dunbar Hutchinson ..... Trenton
Earl H. Snavely ..... Newark
Frederic J. Quigley ..... Union City
Jacob J. Mann ..... Perth Amboy
W. E. Darnall, Atlantic City, substituted for Dr. Snavely. (Sect. 21)
(Report, Sect. 83)

III. Credentials

H. Roy Van Ness, Chairman ..... Newark
J. Bennett Morrison ..... Newark
Elias J. Marsh ..... Paterson
(Report, Sect. 84)

IV. Miscellaneous Business

D. Leo Haggerty, Chairman ..... Trenton
George F. Dandois ..... Wildwood
Frederick H. Morrison ..... Newton
William L. Williamson (Sect. 21) Bayonne
Wright MacMillan ..... Passaic
(Nothing was referred to it.)

I would entertain a motion at this time that the Chair be officially empowered to appoint these Reference Committees and that all reports of the committees and officers, compositions and resolutions, shall be referred to these Reference Committees without debate, with one exception, if you wish it, this morning. The By-Laws provide that a report of the

Committee on Budget and Finance shall be made on the first day of the House of Delegates and may be debated, but that no final action can be taken until the last day.

I should like to explain a bit further the purpose of the Reference Committees is to facilitate the transaction of business which cannot be properly and carefully considered before such a large group.

I would ask now that the Chairmen of the Reference Committees, as soon as possible, publish notices of where they will hold the meetings of their committees, and at what time. The delegates who are interested in the reports which they will consider may appear to present their views upon those reports. Full consideration of the opinions of any delegate should be given by the Reference Committees. Then the Reference Committee will return a report to this body at our last session, when the reports will be open for debate and action.

Do I hear a motion from this body on the appointment of the Reference Committees and on this method of procedure?

Secretary Morrison: I move it be so adopted.

The motion was regularly seconded.

President Snedecor: It has been regularly moved and seconded that the list of Reference Committees as published be approved; and that the reports of committees and officers, resolutions, and compositions, be referred to the Reference Committees this morning without debate, with the exception of the Report of the Committee on Finance and Budget.

The motion was put to a vote and was carried.

President Snedecor: We will now take up the report of the officers and committees as published in the last Journal.

9. President's Report

(Jour., April, p. 225)

The first report to be considered is the President's Report, and I hope that all the delegates will refer to these reports. I hope you brought them with you. If you haven't any, I hope the Executive Office will be able to supply you with some of them. I call your attention simply to the recommendations in my report. I am submitting the following specific recommendations to the House of Delegates for consideration;—

President Snedecor read excerpts from his jections to the method of procedure, I shall p. 226 and p. 227, paragraphs marked 1, 2, 3, and 4, under the subhead "Recommendations", which are as follows:

RECOMMENDATIONS

As a result of my experience during the past year, I am submitting these specific recommendations to the House of Delegates for consideration:

1. That the tested reorganization and integration of the various committees under the Welfare Committee be approved.

2. That the Public Relations program as now getting under way, with plans for contacts and the spread of medical information, be endorsed.

3. That the general Public Health policies, as reported by the individual advisory committees, be supported and approved.

4. That the general policy of building up both the State and county society organizations, in order to more effectively preserve our practice and carry out our health responsibilities, be encouraged.

President Snedecor: I will refer that to the Reference Committee "A".

Action, Sect. 74 A.

10. Report of Executive Officer Wilkes

(Jour., April, p. 227)

We can have supplementary reports, and they are limited to five minutes. First, from the Executive Officer, Dr. Wilkes.

Dr. LeRoy A. Wilkes read the Supplementary Report of the Executive Officer, as follows:

SUPPLEMENTARY REPORT OF THE EXECUTIVE OFFICER

ANNUAL MEETING

Since the printed report of the Executive Officer was made, a large part of the time of the Executive Office staff has been devoted to Annual Meeting details.

LEGISLATION

The Legislature is still in session and several cult bills are still in committee and need constant supervision. A bill (A-425) to provide free typing and serum for *pneumonia* cases has been receiving the attention and consideration of our *special* Advisory Committee on Pneumonia. They have approved this bill and our Key-men have been asked to urge its support in both houses. Because pneumonia must be typed and the proper serum given *early*—usually *before* the case is hospitalized, we feel that this aid to the physician in indigent cases is urgently needed.

PNEUMONIA

Pneumonia is also an important Public Health problem, because the respiratory diseases contribute significantly to our mortality in New Jersey. This bill has the support of the State Department of Health. The Insurance Companies and at least one of the Foundations have contributed funds for studies of control measures against this disease.

VENEREAL DISEASE

The Venereal Disease Program is getting actively under way with our aid.

POST-GRADUATE COURSES

Post-Graduate Courses, especially in pediatrics, for the general practitioner are attracting large audiences.

PRESIDENT SNEDECOR

President Snedecor has proven himself to be a good executive and keeps everybody busy upon some definite task pointed at definite objectives. He has worked hard himself and is not satisfied with gestures. He has sought results, and it has been a great pleasure to work under his direction.

NEW OFFICES

The new offices command the respect of all visitors from other community agencies and provide ample space for the State Society activities.

One prominent lawyer spoke of the dignity and efficient organization of the Medical Society and stated his belief that the Society had made a good investment of time and money in the last few years. He expressed the wish that his colleagues would go and do likewise.

The staff members in the Executive Offices have devoted a great deal of overtime without compensation and have thereby proved their loyalty, efficiency and personal interest in the work.

HANDBOOK ON PREVENTIVE PRACTICES

Requests and commendations continue to come from other State and County Societies, medical schools, the Foundations and Health Departments for the Handbook on Preventive Practices, and constructive criticisms and suggestions have been invited from all to whom copies have been sent. This booklet should grow in size and usefulness and be reprinted in the future as newer knowledge is accumulated. The booklet is a pioneer effort and is so hailed by recognized authorities.

We are all ready to give to Dr. Herrman the same loyalty and service in his efforts to carry on during his administration, and to serve all the members in such ways as the House of Delegates and the officers shall decide.

LEROY A. WILKES,
Executive Officer.

PRESIDENT SNEDECOR: I should like to add to that simply that it is a pleasure for any President to have the loyal support of an Executive Officer like Dr. LeRoy Wilkes. His services to me have been invaluable. His services to the Society are given unstintingly, without thought of time or effort, and I commend his report to you and refer it to Reference Committee "A".

Action, Sect. 74 B.

11. TREASURER'S REPORT

(Journal, April, page 229)

The next report is that of the Treasurer, Dr. Marsh.

DR. ELIAS J. MARSH: Inasmuch as the fiscal year does not close till May 31, no report of the Treasurer can be made at this time. The report will be presented in full to the first meeting of the Trustees after that time, and will be published in the Journal (June, p. 392).

See page 8 for report of May 31, 1937, as published in the Journal of June, 1937, p. 392.

That, however, does not mean that the Treasurer hasn't something to say this morning, for I have. I know you are interested in the finances and the balances of the Society, and I have prepared certain figures to show you.

There is every year a certain amount of interest aroused by the sight of the balance as reported, and it is difficult to understand, I admit, on account of the fiscal organization of this Society, because that balance necessarily includes an indeterminable item of the amount of money necessary to run the Society from the time a report is made, the first of June, till the 31st of December following, when the new assessment is due, and it has always been a matter of uncertainty just how much is included in this balance.

Some time ago I had a consultation with an expert accountant, and last week with another one who came up from Trenton to consult me about this matter; and there is no positive way of determining just what the figure is, but I will show you very approximately, and show you it is not nearly so large as it appears in the balance.

Treasurer Marsh exhibited a blackboard on which appeared the following:

TREASURER'S STATEMENT

	1937	1936	Change
Operating expenses to Apr. 27th	$48,250	$38,390	+$9,360
Balance—cash	49,320	49,800	— 480
Balance, May 31st	45,000 (estimate)	43,870	+ 1,130

TRUE BALANCE (estimated)

Proposed budget	$66,800
7/12 of this (June 1-Dec. 31)	39,000
Expected income (June 1-Dec. 31)	7,000
Required for operation to Dec. 31	$32,000
Cash Balance—May 31	$45,000
Less requirement as above	32,000
True Balance	$13,000
Reserve for depreciation	2,500
Free Balance	$10,500

ANNUAL REPORT OF THE TREASURER FOR THE FISCAL YEAR 1936-1937

PERMANENT FUND

May 31, 1936—	
2M U. S. Treasury 3¼% bonds of 1943-5	$ 1,997.50
1M U. S. Treasury 3¼% bond of 1944-6	1,034.38
1M U. S. Treasury 3% bond of 1946-8	1,014.06
Mortgage Certificates, Investors Title & Mortgage Co.	3,000.00
Mortgage Certificates, Trenton Mort. & Title Guar. Co.	2,625.00
Savings Account, First National Bank of Paterson	5,394.31
	$15,065.25
May 31, 1937—	
2M U. S. Treasury 3¼% bonds of 1943-5	$ 1,997.50
1M U. S. Treasury 3¼% bond of 1944-6	1,034.38
1M U. S. Treasury 3% bond of 1946-8	1,014.06
Mortgage Certificates, Investors Title & Mort. Guar. Co.	2,910.00
24-15/100 shares, Trenton Mortgage Service Co.	2,415.00
Savings Account, First National Bank of Paterson	5,694.31
	$15,065.25

CHARLES J. KIPP MEMORIAL FUND

(Eye, Ear, and Throat Section)

May 31, 1936—	
Deposit, Howard Savings Institution	$30.00
May 31, 1937—	
Deposit, Howard Savings Institution	30.00

GENERAL ACCOUNT

RECEIPTS

Balance, May 31, 1936		$ 43,867.65
Assessment—		
Atlantic	$ 1,612.00	
Bergen	2,999.75	
Burlington	728.00	
Camden	2,327.00	
Cape May	312.00	
Cumberland	715.00	
Essex	11,326.50	
Gloucester	533.00	
Hudson	5,720.00	
Hunterdon	325.00	
Mercer	2,600.00	
Middlesex	1,518.00	
Monmouth	1,875.25	
Morris	1,378.00	
Ocean	325.00	
Passaic	4,433.00	
Salem	260.00	
Somerset	728.00	
Sussex	273.00	
Union	4,004.00	
Warren	455.00	
		44,447.50
Publication receipts		9,895.09
Interest		782.33
Commercial Exhibits, Annual Meeting, 1936		2,770.00
Commercial Exhibits, Annual Meeting, 1937		2,283.23
Miscellaneous		43.80
		$104,089.60

PAYMENTS

For Publication Committee		$ 14,396.58
" Salaries:		
Secretary	$1,375.00	
Executive Officer	6,000.00	
Executive Officer, bonus	1,000.00	
Editor	5,000.00	
		13,375.00
" Office operation:		
Clerical services	$5,353.00	
Operating expenses	832.65	
Travel	615.64	
Furniture and equipment	646.11	
Liability insurance	143.64	
Moving	69.50	
Rent	1,284.38	
		8,944.92
" Expenses of officers:		
President	$1,881.30	
Secretary	2,093.11	
Treasurer	99.80	
		4,074.21
" Committees:		
Welfare	$1,090.23	
Public Health	2,110.41	
Public Relations	699.32	
Trustees	240.45	
Judicial Council	118.13	
Medical Practice	229.76	
Other committees	139.75	
		4,628.05
" Annual Meeting, 1936:		
Program & arrangements	$1,185.87	
Credentials Committee	529.09	
Scientific Exhibit	2,728.65	
Scientific Work Committee	131.75	
Executive Office	133.03	
Woman's Auxiliary	367.56	
Arts & Hobbies Committee	91.16	
Guests	267.27	
		5,434.38
" Printing and stationery		1,916.68
" Legal services and expenses		2,133.46
" A. M. A. Delegates, railroad fares		435.70
" President's educational letters		1,019.98
" Tri-State Medical Directory		865.85
" Woman's Auxiliary, for A. M. A. meeting		400.00
" Increasing office cash fund		500.00
" Conference of Allied Medical Professions		25.00
" Miscellaneous		130.07
" Annual Meeting, 1937; advance to new budget		1,288.10
Balance, May 31, 1937		44,521.62
		$104,089.60

BUDGET RECONCILIATION

Expected income	$55,800.00
Actual receipts	60,221.95
Budget appropriations	57,260.00
Expenditures	59,567.98
Operating net balance	653.97

Respectfully submitted,

E. J. MARSH, M.D., *Treasurer.*

TREASURER MARSH: Now, here are certain figures——

DR. SHAPIRO (Hudson County): A point of order! Hudson County objects to this form of report. On page 22 of the By-Laws it states distinctly the duties of the Treasurer: "* * * he shall render at each Annual Meeting of the Society a full statement of all transactions of his office." This is not a full statement of the transactions, and we object very strongly to any dissertation of this kind.

PRESIDENT SNEDECOR: The Chair will consider that Dr. Marsh's report is being properly given.

DR. SHAPIRO: Will you put that in the minutes, please,—that Hudson County is objecting to it? It is not in conformity with the By-Laws of the State Society. It says distinctly: "* * * he shall render at each Annual Meeting of the Society a full statement of all transactions of his office." This is not a full report.

PRESIDENT SNEDECOR: Dr. Marsh, will you continue with your report?

DR. MARSH: The expenses at April 24, from the first of June of last year, are $48,240; in 1936 they were $38,390, so that this is nearly $10,000 more than they were in the same period last year. The Society's different activities have been spending money pretty liberally. The actual cash balance last Saturday, and it remains the same today for I have paid no bills since, was $49,320, as against $49,800 last year, or $480 less.

Now the balance at the close of the fiscal year, up to May 31, of course, I can only estimate, from the best experience that I have. We have substantial bills coming in, I am told, also somewhat larger receipts from the Publication Committee and other sources, than I had expected, and this estimate is the best I can do. I estimate we will have $45,000 balance on the 31st of May as against $43,870 last year, or an average of thirty cents per man more than we had last year, thirty cents per member.

That balance includes the money necessary for the running of the Society till the 31st of next December. Here again we have to estimate more or less, and the only way that we can determine the balance is by taking out that money so far as we can, which is to say, seven-twelfths of it, for June, July, August, and so forth, through December, for the expected operating expense of the year. Seven-twelfths of the budget that will be proposed to you shortly is $39,500. That is all I have to estimate on now. The figures may be changed, but that is the best I can do now. In the meantime, I expect to have other income from belated assessments, from the Journal, and from the profits of this meeting, and so on, amounting to about $7000, which leaves this balance required for operating expenses of the seven months of this year, this much, $32,500.

The difference between that and this leaves us what may be called a surplus. The real balance is $12,500. From that I wish to hold for a certain contingency fund, for certain contingencies and possible losses one place or another, a reserve of $2500, leaving really a balance of $10,000, or about $2.95 per man, which I think is not an excessive reserve or surplus to carry an organization like this, doing a business of $60,000 or $65,000 a year.

The expenses have been going up right along every year. Really, the balance is not as stated here, $45,000. It is about $10,000, as nearly as any accountant can tell me how to estimate.

There is one thing I want to say about this balance. It has been said that we have been setting aside or piling up a reserve, and so forth. Well, that is true to this limited extend. We don't know—I am not going to report for the Budget Committee, but I will explain to some extent the balance. It is true to some extent that we have accumulated that money, but that is not intentionally or deliberately accumulated in any way. It is the result of the difference between the budget estimates of income and outgo, and the actual experience of each year for a number of years.

There are different ways in which business of that sort can be done. It has been the practice of the Finance Committee to be conservative in estimating receipts and to be fairly liberal in estimating expenses, because that is a safe way to do. Then if you are conservative in your receipts and you get more than you expected, you are that much to the good; otherwise you may be in trouble. If you are too conservative in your expenses, the same thing may happen the other way.

There is another way of doing it. Down in Washington we have all read in the papers recently they anticipate a handsome income from large recovery of business, and so forth; and, on the other hand, they have a good many agencies, the W. P. A., boondoggles, and so forth, that like to see how fast they can spend money, and the result is that there is a deficit of, this year, according to their estimate, $418,000,000. If we wish to conduct our business on that same plan, I don't think we can run

into a deficit of $418,000,000, but it would be easier to run into some kind of deficit than to have $10,000 left where it is safe.

Thank you, sir. (Applause.)

President Snedecor: Thank you, Dr. Marsh, for your explanation of a difficult problem, the financial statement of the State Society.

Dr. Joseph F. Londrigan (Hudson County): The expenses as I see it for 1937 were $48,000. The appropriation was $57,000. Where is the $9000? That is the balance from that. The appropriations of 1935 and 1936 were $44,000. They increased their appropriations to the budget $13,000 for 1936 and 1937. I don't know what they have increased their appropriations to for 1937 and 1938, but I should like to know from Dr. North, who is present here,—if they increase their budget $13,000 in one year and don't even spend it, I can't see where there is only a balance of $10,000.

Dr. Marsh said this was correct. Those figures are entirely wrong. I can show you in 1933, $34,000; in 1934, $34,000; in 1935, $35,000; and in 1936, $43,000. That is not a surplus but a profit that this Society is making, and these figures are all wrong.

President Snedecor: Dr. Londrigan, I have no wish to stifle a discussion of the Treasurer's Report, but it would require a change in the order of business. The first resolution we passed was that these reports be referred without debate to the Reference Committee. Now, if the Society wishes to change that, I am perfectly willing to change it.

Dr. Londrigan: The By-Laws distinctly say——

President Snedecor: You have heard the Report of the Treasurer——

Dr. Londrigan: I certainly have not, and I certainly do wish to hear a report of the Treasurer, and according to our By-Laws, he "shall" report, not "may" report.

President Snedecor: I will then proceed to ask the advice of the Assembly. Will you assure me one way or the other whether you feel you have heard the Report of the Treasurer of The Medical Society of New Jersey? May I ask for a vote on that?

Member: You are out of order.

President Snedecor: The Chair is asking for advice. All those who feel that they have heard the Report of the Treasurer of the Medical Society will please say "aye"; opposed, "no". Let's have a rising vote. All those in favor please rise. The "ayes" have it.

Dr. Londrigan: I call for a negative vote.

President Snedecor: The Chair rules we have heard the Report of the Treasurer of The Medical Society of New Jersey, and it is now referred to *Reference Committee "A"* for consideration.

Dr. James F. Norton (Hudson County): May I ask one question about the figures on the board?

President Snedecor: Again I rule——

Dr. Norton: This is not a question of debate. I want to ask one question about one item on the board, without debate. If he doesn't want to explain it, I will withdraw the question.

President Snedecor: Dr. Marsh, do you care to answer a question proposed by the gentleman from Hudson County?

Dr. Marsh: What is the question?

President Snedecor: He hasn't asked it yet.

Dr. Marsh: Yes.

Dr. Norton: In 1936 you have this figure here, $49,800, and under this, the same figure of the balance that appeared in your Annual Report at the end of the year 1936.

Dr. Marsh: So far as I remember, I think it is. I haven't got that report here.

Dr. Norton: May I ask that the reporter make a copy of this report as it stands on the board, so that we can compare it with the official report of Dr. Marsh for the year 1936 that I hold in my hand? That is all.

President Snedecor: May I ask Dr. Marsh——

Dr. Marsh: No, it is not. This is the figure, $43,870. That report didn't occur in 1936. This is the figure that occurred in 1936. Here it is as it appeared in the report, $43,867.65. I changed it to $70 for convenience, that is all; but that is the figure, not this one. That first is the figure of last year, on April 24, which I made to compare with the figure of this year. That is the last date that I have, last Saturday.

President Snedecor: That is enough, if you don't mind, Dr. Norton.

Dr. Norton: What does the figure opposite there refer to—May 31, 1937?

Secretary Morrison: Yes.

Dr. Norton: We are not up to May 31, 1937.

Dr. Marsh: That is what I estimate. That is the balance last year, there.

President Snedecor: Thank you, Dr. Marsh. This report of the Treasurer is referred to Reference Committee "A", and I

hope the Chairman, Dr. Sprague, will publish the time of the meeting.

We will try to have the meeting places of the Reference Committees posted at the registration desk.

Action, Sect. 74 D and 74 E.

12. Report of Finance and Budget Committee

(Jour., April, p. 229)

The next report, according to our resolution, is open to debate; that is the report of the Committee on Finance and Budget, Dr. North.

Dr. Harry R. North: Mr. President and Gentlemen: I want to make this statement to start with: The Committee on Finance and Budget does not determine policy. We are here for the purpose of trying to find out a per capita assessment when the budget is given us. In order to facilitate matters, this year we will throw the figures on the screen, because it is confusing and I want to say that they can't stay there long because the glass will crack.

The Medical Society of New Jersey

BUDGET—1937-1938

Executive		$14,590.00
Executive Officer—salary	$7,000.00	
Office Manager—salary	1,560.00	
Clerk-stenographer—salary	1,040.00	
Clerk-stenographer—salary	1,040.00	
Extra clerk (4 months)	250.00	
Overtime (4 months, 5 girls)	800.00	
Office expenses	1,400.00	
Travel	1,500.00	
Executive assistant		4,000.00
Journal		7,360.00
Editor—salary	$5,000.00	
Secretary—salary	1,560.00	
Overtime (1 month)	50.00	
Office expenses	500.00	
Travel	250.00	
Rent—State Headquarters		2,880.00
Publication—Journal		13,200.00
Publication	$13,000.00	
Cuts	200.00	
Welfare Committee		10,450.00
General Welfare	$4,500.00	
Welfare Committee	1,200.00	
Legislative Committee	250.00	
Public Health Committee	1,500.00	
Public Relations Committee	2,000.00	
Medical Practice Committee	1,000.00	
Treasurer		75.00
Secretary		1,500.00
Annual Meeting		2,500.00
Program and Arrangements	900.00	
Guests	200.00	
Art, Hobby, and Medical History	200.00	
Woman's Auxiliary	400.00	
Scientific Exhibits	800.00	
Printing		2,000.00
President's Fund		2,000.00
A. M. A. Delegates		500.00
Joint Conference Professional Relations		100.00
Conference Allied Medical Professions		25.00
Contingent		3,000.00
Legal		2,500.00
Total		$67,680.00
Less		1,000.00
		$66,680.00

$15.00 per capita.

We will first take up the Executive Office. You see yourself the salary is $7000 for the Executive Officer; for the Office Manager, $1560; clerk-stenographer, $1040; second clerk-stenographer, $1040; extra clerk (four months), $250, which experience has proved to be correct; overtime (four months, five girls), $800, which by experience has been proved correct; general expense, $1400; and travel expense, $1500; making a total of $14,590.

The second item is Executive Assistant, $4000.

The next item is a rent item, $2880. I might say that the rent is considerably more than it has been in the past. When we first rented the State Offices, we had three rooms for a very small figure, $80 a month. It would have cost us anywhere else in Trenton $150 for similar rooms in a better building in Trenton, and they threw in two extra rooms which they weren't using, so it would have cost $200. The building was sold and the best we could do was this increase in rent.

Journal: Editor, salary, $5000; secretary, salary, $1560; overtime (one month), $50; office expense, $500; travel, $250; making a total of $7360. Publication of Journal, $13,200, $200 being for cuts, which doesn't really belong to the Journal, but we put that in.

Welfare Committee: I will take a second on that item. First, Welfare Committee proper, $1200; Legislative Committee, $250; Public Health Committee, $1500; Public Relations Committee, $2000; Medical Practice Committee, $1000; and we will go back to the General Welfare, $4500. That takes care of some fifteen committees and is put in there primarily

because we feel that these committees should not spend more than has been allocated to them without permission of the Welfare Committee Chairman and the President. It is simply a safeguard and that Welfare Committee totals $10,450.

The next item is the Secretary, $1500, and the Treasurer, $75.

Annual Meeting: This year we tried to put the expenses together; program and arrangements, $900; guests, $200; Art, Hobby, and Medical History, $200; Woman's Auxiliary, $400; and Scientific Exhibits, $800.

Printing account, $2000; President's fund, $2000; A. M. A. Delegates, $500; Joint Conference Professional Relations, $100; Conference Allied Medical Professions, $25; contingent, $3000; legal, $2500.

That last is wrong. It should be a total of $44,480.

I want to say this as a member of the Budget Committee, if you wish this budget to pass, if you wish your State Society to carry on its program, and if we are going to have this as our budget, then it is necessary, we feel, to make a per capita assessment of $15.

Dr. Marsh says over there that he has practically a free balance of $10,000. If you make the dues $15, it won't be quite so free, because I think it will take away from that something like $5,000; so that the best we can estimate is that this so-called surplus that occurs from year to year will still be about $5000.

Personally, I will be frank to tell you, I have deliberately kept a little ahead. I felt it was perfectly proper to have a small surplus. I don't know that there is anything else, unless you want to ask me some questions that I can't answer.

President Snedecor: Does that constitute your report at the moment?

Dr. North: Yes. We recommend $15 per capita assessment.

President Snedecor: Gentlemen, you have heard the Report of the Chairman of the Committee on Finance and Budget. It is now open for debate.

Dr. Maurice Shapiro (Hudson County): May I present a resolution passed at the Hudson County Medical Society on April 6, 1937, in reference to dues, so it will be on record here?

"Whereas, The dues assessed against the members of The Medical Socitey of New Jersey are considered by many to be excessive; and

"Whereas, As this particularly concerns Hudson County, $13.00 of every $18.00 is given over to the State Society; therefore be it

"Resolved, That the Delegates of the Hudson County Medical Society to the next State Convention be now instructed, to make diligent inquiry of the President, Executive Officer, and the Secretary of The Medical Society of New Jersey concerning the finances, salaries, expenditures, and general budgeting of The Medical Society of New Jersey with a view of effecting some economies in the management of the State Society which would reflect themselves in a reduction of the State Society assessment of $13.00."

Action. Sect. 83.

President Snedecor: That is in the nature of a resolution.

Dr. Shapiro: Made at the Hudson County Medical Society. We want that in the record.

President Snedecor: And, as a resolution, I believe it should be referred to the Committee on Resolutions and Memorials, and I hereby refer it to Reference Committee No. 2 and that is on Resolutions and Memorials. Is there further discussion?

Dr. James F. Norton: Mr. President and Fellow Delegates to this Convention: This is a duty imposed upon me as Chairman of the Hudson County Delegation, and I am now talking in answer to specific instructions to discuss this matter with the Chairman of the Budget Committee and discuss it, if need be, from the floor. It is an entirely impersonal proposition as far as I am concerned.

The Hudson County Medical Society is looking for information. Frankly, for the last year, for the last two years, perhaps, we have had little or no contact with the State Society. We know absolutely nothing regarding the policies, the program, or the expenditures of the State Society, and in order to obtain any information, we have to write to the officers and I must say that when we have written we have received very cordial consideration. It makes it difficult, however, and it put us always in a bad light. It puts us in the light of being more or less perpetual objectors, or chronic kickers, and we want definitely to dissuade you from that idea. We are not that at all.

We know nothing of what is going on in the State Society. During the past year we had a short visit from the President-Elect of the State Society. We had no contact with any other member of the State Society. We saw no member of the Judicial Council or Board of Trustees or Finance Committee, nor the Executive Board of the State Society, and we are at an absolute loss to know what is going on, so it doesn't entirely appear out of order if we come before this convention and ask some questions.

We had a membership drive in Hudson County last year and we stand today in Hudson County with a large membership, with the largest registration or membership in the Hudson County Medical Society we have ever had at any time in the history of the Hudson County Medical Society. That was possible only through a very energetic drive on the part of a few very able and public-spirited members of our Society; but they have reported back that they have run into an endless amount of difficulty in getting men into the Society on the one score of dues.

I am now reflecting to this Convention the attitude of the non-members, particularly of the Hudson County section, and giving their reason for not joining the Hudson County Medical Society. We have in that society approximately 425 or 430 members. There are approximately in Hudson County, I think, now seven hundred doctors; in other words, there is still a good group of men outside of the County Society that we ought to have in, and this is their reason for not coming in. I am certain that that condition obtains throughout the rest of the State.

According to the last issue of the A. M. A. Director we have 3200 or 3300 men in the State Society, and there are 5200 or 5300 doctors in the State of New Jersey. Dr. North tells me we have 3400 in the State Society.

I am not here to argue policy or indicate that we should have a membership drive throughout the State to get the other two thousand men, but I personally believe that a lot of them can be brought in. Essex County has a membership of approximately 780 or 790 men.

Secretary Morrison: Nine hundred.

Dr. Norton: The last copy of the American Medical Association Directory gives Essex County a little less than 800. There are in Essex County over 1300 doctors. There are 500 doctors in Essex County alone who are not members of this Society. My last figure was in the last issue of the A. M. A. Directory. Those are the only counties I touched. I wasn't particularly interested in making an exhaustive statistical analysis of the situation. I wanted to pick out the two largest.

So there are probably about eight or nine hundred men who are not in the Society. That is an indictment against us. We ought to be able to interest them. If we are serving the purposes of the physicians as well as we are led to believe we are serving them, then these other eight or nine hundred should want to join the Society, and you should not have to go out and, for the want of a better word, "coerce" them. That is the premise upon which my whole presentation rests, that there are a very large number of men outside of this Society who should come in, and particularly and specifically as it relates to Hudson County, the argument is dues.

We were instructed to come here and ask for a reduction in the State assessment, and we were prepared to offer some figures to show that we should probably have a reduction. They are the only figures we have and they are certainly debatable. We were not at all prepared for an increase of dues to the tune of $2 a man.

Now, I have jotted down some notes as Dr. North's slides went on the board and there are a couple of things in here that I want to take up. I am told that the Official List shows Essex County with 788 men. The A. M. A., as I said before, shows Essex with 1300 doctors.

Again I state, and I want to restate and reiterate almost to the point of boredom, that I am not reflecting my own personal opinions. I am speaking for the Hudson County Medical Society.

A few years back this Convention dispensed with the services of Dr. Reik, on the argument of economy, and if I remember rightly—I am wretched as far as figures are concerned—I think he got a salary of $11,000 or $12,000.

Dr. North: Ten thousand.

Dr. Norton: Ten thousand dollars. That was only a few years back—economy! I happended to be in the House of Delegates the day that resolution was debated, and I still remember the argument presented,—economy, economy, and economy;—and the argument prevailed, and I thought it was a good argument, and I thought at that time it should prevail.

We are now asked to raise the salary of the Executive Officer from $6000, to $7000. In addition to that, the Executive Officer has an office or running expense of somewhere around $16,000. That is just the Executive Officer. That is just one part of the $10,000 that we were going to economize on when we dispensed with Dr. Reik's services. Over and above that there comes now a request that was not enlarged upon. It was flashed on the screen and immediately taken off—a new position.

Dr. North: Not intentionally.

Dr. Norton: Again, this is not personal. It is an Executive Officer for $4000. According to the Report of the Chairman of the Board of Trustees, this $4000 Executive Officer is the first of two assistants to the Executive Officer who are to be appointed within the

year. If again my memory serves me, the words of the Chairman of the Board of Trustees are that within a short time it will be necessary to add a second assistant to the Executive Officer. That brings us up close to $20,000, where Dr. Reik originally got $10,000.

We now go over to the question of the Journal. We have an editor of the Journal, $5000, and a secretary and stenographer, and all together, including the publication, running the account for the Journal to about $20,000 or $21,000—$13,00 to publish the Journal, $7300 to run the office.

We in Hudson County particularly, and I am speaking for Hudson County—I don't want my position to be misunderstood, have not received from the State Society anywhere near the value in services from the State Society that we have paid, $13 per man, per capita tax. We have a legitimate, absolute argument against the dues staying at $13; and we have a much better argument against paying an increased assessment of $2000.

We have no contact whatsoever, and we have received nothing in return, practically, from the State Society. "Nothing" should be qualified.

The Welfare Committee comes in with an expenditure, a contemplated expenditure of $10,450. It is split up in General Welfare, $4500, with no further explanation. The Welfare Committee has $1200, and so forth with other items along in the budget. Very frankly, I know nothing at all about the activities of the Welfare Committee; and just as frankly, we have made definite, specific, deliberate, persistent attempts in Hudson County to find out about it, and I am quite well aware of the fact that in a discussion of the budget the State Society is not the place to find out what the Welfare Committee is doing. That should be found out at other times and in other places.

Secretary Morrison: Dr. Norton, have you not in Hudson County, members of the Welfare Committee?

Dr. Norton: Thank you, Dr. Morrison, for giving me a chance to speak on something I was specifically going to shun. We don't know what the Welfare Committee is doing. In answer to Dr. Morrison's interruption, may I say that we have on the Welfare Committee of the State Society five members. As to the Welfare Committee, this might help to explain our attitude, and again I want to insist we are not here in the rôle of chronic objectors. The only place we have to find out anything is in here.

We have five or six members on the Welfare Committee, and we had a visit from the Chairman of the Welfare Committee, and he said, out of a total possible attendance, five members at four meetings, Hudson County was represented at twenty meetings—four of the twenty meetings. He accredited it to Dr. Pollak. He had an attendance record of 100 per cent. One or two of them were accredited to Dr. Schuck, the Immediate Past President of Hudson County Medical Society who for quite some time past has been very, very ill and has been out of practice. The other three members of the Welfare Committee from Hudson County apparently batted .000. Wait till I tell you how that came about.

I can't quote the chapter of the Constitution, or it might be the By-Laws—since there is a difference. I never knew there was much of a difference—but it says that the County Society may suggest to the President of the State Society who its members of the Welfare Committee may be. The Hudson County Medical Society in regular meeting assembled, by formal resolution, directed to the President, submitteed a number of names of those men whom the President thought would most completely, thoroughly, and best represent the interests of the Hudson County Medical Society in the Welfare Committee; and Hudson County's representation on the Welfare Committee was published and announced by the President of the State Society and of the group of men formally presented to the President, two men were appointed, Dr. Pollak and Dr. Schuck.

It proves that the point I started out to make is the reason for our appearing here. We know nothing of what is going on. We can't get representation on the Board of Trustees. We can't get representation on the Welfare Committee, or on any important committee. We go down to Arts and Hobbies and Woman's Auxiliary. We get that and we can show it to you. (Laughter.)

This is a serious matter. Our Nominating Committee delegation formally declares certain people are unacceptable to Hudson County, and in spite of that, we are handed people to represent Hudson County that we don't want representing Hudson County. When they are appointed to these committees, they never go to a meeting of the Hudson Medical Society, and we don't know what is going on.

Now, that might not be sufficient reason, perhaps, as far as the rest of the State is concerned, to curtail these expenditures, but it is sufficient reason for us in Hudson County to come here and make a formal protest—the only place we know where we can make a for-

mal protest, save one, and ask for a statement, an explanation, of what is going on.

Gentlemen, I don't know whether I am out of order, but I will offer a resolution—is there a resolution?—well, I will offer an amendment, if there is—I don't know what it is, but wherever it goes and however it goes, that the dues of the State Society be not raised; that they be held at $13 per man. We won't go on for a reduction because we don't think we can effect it, but I think we have certainly sufficient warrant in these figures for curtailing some expenditures.

The budget this year contemplates an expenditure of $66,680. (Figure taken from slide.) Last year the budget was $42,000—correct me, Dr. North—$57,260, and for the year before?

DR. NORTH: I don't remember, Doctor.

DR. NORTON: Forty-five thousand, roughly; and we don't think there has been sufficient reason shown warranting a raising in the expenditures of this Society in the two years from $45,000 to $66,000, which appears to be a rise in expenditures of about 33 per cent.

I thank you! (Applause.)

PRESIDENT SNEDECOR: The Chair will ask that following Dr. Norton's talk you will please confine yourselves strictly to the question, which is the Report of the Committee on Finance and Budget.

I do not think at this time—I will so rule,—that a motion is not in order. The procedure is for a debate on the budget for the information of the members. It will then be referred to a Reference Committee and proper action will be recommended by the Reference Committee at the final session of the House of Delegates, which may then be amended or disapproved. Any resolution should come up under New Business. We will continue with a debate on the Committee on Finance and Budget.

DR. NORTH: I want to clarify a few things. I am not taking issue with Dr. Norton—I know better. The Executive Officer's salary is not really raised. In last year's budget it was $6000. In this year's it is $7000; however, on both there was granted a budget of $6000, so it comes to the same thing. Now, the Budget Committee looks pretty big when you take $13,000 for the Journal and $7000 for the office, making $20,000, but bear in mind that the Journal will probably bring in this year about $11,000. I think I am safe in saying your Journal costs you about $2 per man. The Journal has quite a revenue, and that is something to be considered.

And one other thing. I wish Dr. Norton, in making that resolution, wouldn't just simply make a flat statement that he wants to reduce the dues. You can't reduce the dues if you pass this budget, and I wish if they want to reduce the dues, they would attack the individual articles on the budget and show us how we can reduce the dues.

DR. NORTON: I am going to meet you tomorrow night before the budget is passed.

DR. NORTH: I am looking forward to it with great pleasure.

PRESIDENT SNEDECOR: I should like to explain thoroughly that the Finance and Budget Report will not come up for final adoption till the last meeting of the House of Delegates; and that should give everyone a chance to express himself, and the Reference Committee will express themselves, and Dr. North and Dr. Marsh will be present to answer any questions.

DR. NORTH: I want to say that we had a meeting of the Finance Committee in Newark some weeks ago; and as a committee, we were not satisfied with the requests for money from the different committee chairmen. And we then had a second meeting and called these committee chairmen on the carpet, and, after a lengthy discussion, we felt they were justified in what they asked, so this wasn't just a haphazard piece of guesswork. We really attempted to find out just exactly what the State Society needs; and certainly Dr. Norton, when he talks about jumping the Journal $10,000 a year, well, we are doing so much more than we used to in the days of Dr. Reik—and I was a friend of his. The work is ten times as great as Dr. Reik ever thought of doing. You can't run ten times as much work on the same amount of money.

DR. NORTON: We will discuss that tomorrow night.

DR. LONDRIGAN: I have here in my hand all the official documents from your Society; and I want to show that this surplus you are talking about is a profit, when you talk about surpluses, and if it were my business, I would love to be able to make it, it would be swell for me, every one of the May 31st, 1933, '34, '35, and '36, all May 31st. If you read the figures, it is $24,636.04, in 1933, May 31st.

DR. NORTH: Is that the amount in the bank at that time?

DR. LONDRIGAN: In the bank, absolutely. Then 1934, May 31, $30,145.04, a profit of $5000 in that year; 1935, $35,138.06, another profit of $50000; 1936, $43,867.65, May 31, a profit of $8000. That is not a surplus. There are your figures.

Now, the Board of Trustees has thought they are going to spend this money. They increased their budget from $44,000 in 1935 and 1936 to $57,000—there is $13,000. If they would reduce their dues $3 a person, it would make them still have $4000 more to give to their committee, and they would have $50,000 to put in the budget, and we would get two hundred members and Essex probably would do likewise.

Those figures don't lie. They are your own figures. We didn't bring them out here at all, and if any chairman of any committee, or any Treasurer, Dr. Marsh, or anybody else can tell me that isn't a profit each year, I don't know my figures. I should love to make that money in the practice of medicine, as I do every year. I love to be able to do it, and I am opposed to any increase of dues.

Secretary Morrison: May I say a word? The Hudson County representative in the remarks just made, is wrong. There is no such profit. The only property that the Medical Society of New Jersey possesses today is the money in the reserve, which used to be worth $15,000, which is worth today $12,500. All these surpluses had been expended in meeting the expenses of the Medical Society of New Jersey.

Dr. Londrigan: The Chairman of the Welfare Committee said he had $22,000 surplus in the bank, December 31, 1936, before they got their dues for the ensuing year.

President Snedecor: Now, I prefer not to have any of you men speak more than once. We will accede to the Chairman of the Committee.

Dr. North: Figures don't lie, but they are very confusing. This is purely a balance in the bank. It doesn't mean a thing. This year was bigger, yes; but the bills were bigger. The budget was still bigger in 1936. That is the amount of money in the bank. That is not profit. I venture to say that in all these years there were unpaid bills of $2000, or $3000, or $4000.

Now, the crux of the situation as I see it, is this: Dr. Marsh says that he thinks he will have on hand by May 31, 1937, $45,000. Now what does that $45,000 represent? It is simply a balance in the bank. I have upstairs in my portfolio some $2000 to $2500 in bills that I haven't sent to Dr. Marsh yet. If I had those in, it wouldn't be $45,000: it would be less. That money has to carry us to January 1, or 31st, when the new dues come in, and Dr. Marsh has shown you on the other side of the blackboard that there will be a free balance or surplus, or Dr. Londrigan wants to call it a profit—O.K.—of $10,000 in our treasury.

In our Budget Committee's estimate we have taken the figures of $66,000. We have deducted from those figures the estimated profit of the Journal, $11,000, and so much interest, and some other odds and ends, and, if we make it $15, we are still short, and we have to use about $5000 of this so-called "profit," and we will still have then a surplus of $5000. Now that is as I see it, we will still have a surplus, that is all: in other words, we have $5000 more than we need, provided we spend every cent that is in this so-called budget of this year.

Dr. Londrigan: May I——

President Snedecor: Dr. Londrigan, I acceded to the Chairman of the Budget Committee, but if the rest of us speak once till we are permitted to go around, please——

Dr. Maurice Shapiro: I don't know whether figures lie, but I think we should take a statement as presented by the Treasurer and give it a little thought.

In the 1935-1936 General Account, there is shown a balance on May 31, 1935, of $35,138.44: assets from the counties brought in $42,357.25: publication receipts, $7909.84; interest, $1168.25; exhibits, $844.85; refund from the Scientific Exhibit, $104.71; and miscellaneous, $20.28; giving a grand total of $87,542.62.

We then go back to expenditures, and we find that the expenditures, after being itemized, which must be in accordance with the budget—that, in other words, we spent $44,000, roughly. The budget called for $44,000 that year; and the last item, Balance May 31, 1936, is $43,867.65. The total assets for that year, the list that I gave, plus the balance of $45,000, of May 31, 1935, was $87,542.82.

Now, I can't understand Dr. North, or Dr. Marsh, telling us we haven't got a balance. If we received $87,000, and we spent $44,000, we have got to have a balance, and they can't tell me, and they can't tell my boy who is in high school, that 44 from 87 doesn't leave a balance of 43—$43,000. Now, where is that balance? These figures show how that is increased year after year, but no account is taken of it.

You show that balance last year, and add it to the previous balance, with the same figures that the Treasurer has given, and what has become of that balance.

In the so-called Report of the Treasurer, we have an addition of $2100, and we want to know where that money is. We want to know

why that money can't be used to reduce the dues. Any accountant will tell you when you take $87,000 and spend $43,000, you are going to have a balance, and we want to know what it is and where it is, and we don't want to be told it is an illusionary balance. Prove to us it isn't a balance.

Dr. North: I don't know whether I can prove it to you, but you must remember that that balance of $43,870 represents the dues collected for the next budget. It has to carry us on till January 1. We get our dues in January, but we have our fiscal year end on May 31.

Dr. Shapiro: You take in as much money as you spend, and you still have $44,000 left.

Dr. North: We have it left till January 1.

Dr. Hollinshed: I think that we have had enough of this discussion that isn't going to get us anywhere. Several years ago Reference Committees were appointed to thresh out these problems; and I move, Mr. President, that this matter be referred to the Reference Committee and that these gentlemen from Hudson County present themselves to the Reference Committee, and I think that there will be men there who will be able to explain very definitely why the dues should be raised.

Dr. Fisher: I second the motion.

President Snedecor: Motion that the Report of the Committee on Budget and Finance be now referred to the Reference Committee.

The motion was put to a vote and was carried.

President Snedecor: I now refer the Report of the Committee on Budget and Finance to Reference Committee "A".

Action, Sects. 74 D and 74 E.

13. Report of Board of Trustees

(Jour., April, p. 230)

We will go on with further reports. Next is the Report of the Board of Trustees.

Dr. Frederic J. Quigley: There are two matters that the Board of Trustees desires to bring to the attention of the House of Delegates, which were not included in the formal reports which were published in the Journal this month (April, p. 230).

1. *Councilor Districts.*—You will recall at the last meeting of the House of Delegates a recommendation from the Councilors was made to the effect that the Councilor Districts be increased to seven. It was the feeling on the part of the Councilors that visiting the number of counties they had to, worked quite a hardship on them, and it would be preferable to increase the districts. This report was adopted, this report of the Councilors, by the House of Delegates, and the matter was referred to the Board of Trustees to work out a suggested composition of the new Councilor Districts.

The Report of the Trustees as published in the Journal (April, p. 230) contains our recommendation with respect to the composition of the proposed seven Councilor Districts. Since that report has been published, consideration on the part of the Trustees and on the part of the Councilors leads us to make a recommendation that the matter be reconsidered. The Councilors are unanimous in joining with the Board of Trustees in making this recommendation.

When the matter was under discussion, Dr. Marsh, from whom we received some very valuable thought, made the observation that the work of the Councilors as now contemplated in our By-Laws, makes it necessarry, really, for a man to be a two-type individual, one who has a judicial type of mind and one who has executive or administrative ability to perform the supervising or coördinating activities that are also enjoined upon the Councilors. Whatever excuse or reason, I should say, existed for the Councilors visiting the Councilor Districts, apparently has passed with the President of the State Society, or the President-Elect, or one of the two Vice-Presidents visiting all the County Societies each year, and the Executive Officer likewise, and with the State committees charged with various activities, integrating those activities with corresponding County Societies' committees, so it seems unnecessary to continue that particular function of the Councilors.

So we recommend reconsideration of the decision to increase the Councilor Districts, which will make a number of necessary changes in the Constitution and By-Laws, and let me interject again, following out the instruction of the House of Delegates, the Committee on Constitution and By-Laws has been requested to draw up amendments which would effect this change, that is, increasing the Councilor Districts. If the House of Delegates chooses to reconsider the matter and divorce the supervisory functions of the Judicial Council, it will then be necessary only to delete Section 6 of Chapter VI, Duties of the Officers.

2. *Honorarium to Secretary Morrison.*—The only other matter which we wish to bring to your attention is this: At last night's meeting of the Board of Trustees, the Board was advised by the Secretary of the Society, Dr. Morrison, that he was going to retire as Secretary and would notify the members of the

Nominating Committee from Essex County to that effect.

The following motion of the Trustees, which was moved by Dr. Eagleton and unanimously passed, was that the Board of Trustees recommend to the House of Delegates, in view of the fact that Dr. Morrison is retiring as Secretary, and in view of his length of service, that he be voted an annual honorarium of $1500, his present salary; and it is further recommended that the detail work of the office of Secretary be done by the Executive Officers in Trenton.

The motion was seconded by Dr. Carrington, and unanimously carried. (See Sects. 24, and 75 A.)

President Snedecor: The Chair will rule that the Report of the Chairman of the Board of Trustees be referred to the *Reference Committee "B"*. Through an oversight, it was not published in the program.

Dr. Maurice Shapiro: May I ask Dr. Quigley what section he asked to have deleted? I mean the Judicial Council.

Dr. Quigley: The last section, page 26 of the printed Constitution and By-Laws.

President Snedecor: I am referring this part of the report relating to the Judicial Councilors to the Reference Committee "B", Dr. Ely, Chairman. It does concern the Reference Committee on Constitution and By-Laws.

Action, Sect. 75 A.

14. Report of Committee on Constitution and By-Laws

(Report, Jour., April, p. 231)

President Snedecor: May I at this time tell you about the Reference Committee on Constitution and By-Laws as now published? This committee was appointed by me when I took office, to study the proposals for amendment to the Constitution and By-Laws and report them to your committee; and as a Reference Committee consisting of members of this body, delegates, I shall have to make some changes (see Sect. 15); however, I will now ask Dr. Samuel Alexander, the Chairman of this committee, to make his report.

Dr. Samuel Alexander: Mr. President and Members of the House of Delegates: The Report of the Committee on Constitution and By-Laws was published in the Journal, page 231; and I assume all of you have read it. The reasons for those changes are undoubtedly very apparent to everyone in this room. I just heard Dr. Quigley make a recommendation from the Board of Trustees that we reconsider the increasing of the number of Council Districts and if it be the wish of this group, that will undoubtedly be referred to the Reference Committee for further consideration. At this time, I wish to make a supplementary report for the committee. Most of these changes have been suggested and recommended by the officers of the Society. I have had a great many to look over and have put into this report those I thought ought to come before you for consideration at this meeting.

This is the supplementary report:

By-Laws, Chapter IX, General Fund, Section 2 (a)—On page 34, eighth line, after the word "the" and before the word "together", amend by substituting the words "fifteenth of March" for the "first of February".

(Referring to date on which dues shall be paid.)

The reason for that is very apparent. At the present time the list of delegates must be submitted to the Secretary on the first of February. That has caused a great deal of inconvenience to the component societies, and we thought it best to have the date set as of the fifteenth of March.

By-Laws, Chapter I, Section 4—"Registration at Annual Meeting", on page 12, amend by striking out the words "in the registration book" and substitute therefor "'on an official registration card which shall be duly presented at the registration desk".

The purpose of this change is one of expedience for the delegates who come to this convention. The real purpose is to save time by having the card presented to the delegates and having them fill it out and present it at the desk.

A suggested change in By-Laws, Chapter VI, Section 3—Secretary (p. 20). A suggestion was made but my feeling is at this time that the committee should have more time to study this suggested change, so we are not recommending any change at this time.

By-Laws, Chapter X, Section 3 (p. 36)—Qualifications of Members—Amend by adding the following to subsection (a): "It is hereby required that all physicians applying for membership in Component Medical Societies, shall present to the Committee on Membership or to the Secretary of the Component Society, a license to practice medicine in this State, granted by the New Jersey State Board of Medical Examiners."

At the present time there is nothing in your By-Laws which says that any person applying for membership must produce his license to practice medicine in this State.

Now, By-Laws, Chapter VIII, Section 2—Standing Committees (p. 26). Those who have

been active in medical society work for the past few years have realized that there is a need for a change in the set-up of our Standing Committees, and the following changes are recommended for your consideration:

"The Standing Committees (at the present time) are: Nominating Committee, Committee on Finance, Scientific Work, Program and Arrangement, Publication, Honorary Member, Welfare, Hospital and Medical Education, Committee on Medical Defense, Committee on Insurance, and other committees as the House of Delegates shall determine."

The recommendations are as follows:

"The Standing Committees shall be:
"Nominating Committee
"Committee on Finance
"Committee on Annual Meeting
"Publication
"Honorary Membership
"Welfare
"Post-Graduate Education
"Medical Defense and Insurance
"Woman's Auxiliary
and such other committees as the House of Delegates shall determine."

By-Laws, Chapter VIII, Section 6—Scientific Committees (p. 28). Amend by striking out the entire section and substituting the following:

"Section 6—Committee on the Annual Meeting. The Committee on the Annual Meeting shall consist of five members. It shall have complete charge of all arrangements, plans and programs for the annual meeting and all details pertaining thereto. It shall provide suitable accommodations for the annual meeting, viz: for the general and section sessions, House of Delegates, Trustees, committees, Woman's Auxiliary and exhibits. The general plans for the annual meeting shall be subject to the approval of the Board of Trustees and shall be reported to them at intervals, with a complete outline at least four months before the meeting.

"This committee shall have two subcommittees, one on scientific program and one on scientific exhibits. One member of the committee shall be designated by the chairman, with the consent of the President, as Chairman of the Sub-Committee on Scientific Program. It shall be his duty to arrange for papers, addresses and orations for the annual meeting. He shall see that the speakers are properly received at the annual meeting and that the scientific papers are delivered as scheduled. He may appoint two other men to assist him in the work of this sub-committee. The classification and number of scientific sections shall be determined by this sub-committee. The Chairman and Secretary of the scientific sections shall be elected by each section but shall be responsible to the Chairman of the Scientific Program and shall report to him.

"Another member of the Committee on Annual Meeting shall be designated by the Chairman, with the consent of the President, as the Chairman of the Sub-Committee on Scientific Exhibits. He may in turn designate two other members with the consent of the Chairman, to act as a Sub-Committee on Scientific Exhibits. The duty of this sub-committee shall be to prepare and arrange for all details in connection with scientific exhibits of the annual meeting."

By-Laws, Chapter VIII, Section 7—Program and Arrangements Committee—Delete Section 7.

Chapter VIII, Section 8 (Publication Committee) —Amend to read Section 7.

Chapter VIII, Section 9 (Honorary Membership Committee)—Amend to read Section 8.

Chapter VIII, Section 10 (Welfare Committee)—Amend to read Section 9.

Chapter VIII, Section 10, page 30, Welfare Committee—Amend by striking out sentence beginning on line 8, "the committee shall elect one of its members to act as chairman and executive officer".

Amend sentence beginning line 11, to read:

"It shall have supervision over legislative matters, public health, public relations and medical practice, subject, when necessary, to direction from or approval by the Board of Trustees or the House of Delegates."

Amend by adding to Section 9:

"The work of this committee shall be divided into four sub-committees, Public Health, Legislative, Medical Practice, and Public Relations. Each sub-committee to consist of five members appointed annually, and whose Chairman shall be appointed by the Chairman of the Welfare Committee with the approval of the President. Special advisory committees, of five members each, to these committees may be formed on the approval of the Board of Trustees, and the members will be appointed by the President."

Chapter VIII, Section 11 (p. 30)—Amend Section 11 to read Section 10.

All of the present Section 10 shall be eliminated, and substituted therefor shall be:

"Section 10—Committee on Post-Graduate Education.

"The Committee on Post-Graduate Education shall consist of five members. It shall be the duty of this committee to provide a continuous program of post-graduate education for the members within the resources of the Society. It shall advise upon, correlate and promote all of the post-graduate activities of the special committees in coöperation with educational institutions."

Chapter VIII, Section 12 (p. 31)—Amend Section 12 to read Section 11.

All of the present Section 11 shall be eliminated and substituted therefor shall be:

"Section 11—Committee on Medical Defense and Insurance.

"The Committee on Medical Defense and Insurance shall consist of five members and shall have charge of all matters pertaining to alleged malpractice of members and all other types of insur-

ance, such as health, accident, life, and automobile, which may be recommended to the members.

"It shall have the responsibility for the protection of the members and the contracts and relations with the insurance company. It shall at all times be cognizant of the financial responsibility of the insurance companies, brokers, and agents with whom it is dealing, and shall make frequent reports to the Board of Trustees and annually to the House of Delegates on these meetings. It shall not enter into contracts without the approval of the Board of Trustees or the House of Delegates. It shall maintain contact with the Judicial Council and refer companies of an ethical nature to that body."

Chapter VIII, Section 13—Amend Section 13 to read Section 12.

Delete all of Section 12.
Amend Section 14 to read Section 12.
Amend Section 15 to read Section 13.
Amend Section 16 to read Section 14.
Amend Section 17 to read Section 15.
Amend Section 18 to read Section 16.

I have just been handed some resolutions by members of the House of Delegates for consideration by the Committee on Constitution and By-Laws. This is the first I have seen of them, and I should like to suggest that they be referred to the Special Reference Committee so that we can give it further study and possibly report later in the meeting.

Dr. Maurice Shapiro (Hudson County): May I have the privilege of reading those which were presented to Dr. Alexander?

President Snedecor: I think you will have to—the Chair would rule you will have to bring them in and present them under New Business. Dr. Alexander says it is the first time he has seen them. He wishes to withhold them till further in the meeting.

Dr. Alexander: Those are the changes recommended in the supplementary report. If there is anything that any member would like to know about these changes, I will try to answer.

President Snedecor: If I may say so, in regard to this report, there are many changes we proposed, amendments to the Constitution and By-Laws. I will read first the method by which amendments may be made in these By-Laws:

"These By-Laws may be amended at any annual meeting of The Medical Society of New Jersey by a two-thirds vote of the members present, provided that at least fifty members are present; and, provided further, that the amendments shall have been submitted to the Committee on Constitution and By-Laws, and shall have been twice read in open meeting and laid upon the table for one day."

15. Revised Committee on Constitution and By-Laws

Now, I want to appoint at this time a revised Committee on Constitution and By-Laws, as I see it, to make it conform to membership in this House of Delegates: Dr. Alexander, S. Emlen Stokes, Thomas B. Lee, E. L. Wood, and Frank Scammell. May I ask that the Secretary be sure to notify them. (See Sects. 8 and 14.)

With our experience with the integration of the various committees of the State Society, it is not my purpose to foist anything over on the Society; but to propose these so that they may have full discussion and be brought to the delegates to see if that seems to be a wise procedure. We will have further action.

(Continued in Sect. 17)

16. Appointment of a Parliamentarian

President Snedecor: I have another duty for you here, Dr. Alexander. This Chair feels that it may get into difficulties. One of the recommendations of Dr. Newcomb last year was that a speaker be appointed to preside over the House of Delegates so someone familiar with parliamentary law should be available. There were two or three innovations. It was voted down; but nevertheless, it is my intent, and I believe my prerogative, to appoint a parliamentarian to assist me, to whom I can refer questions of parliamentary order and, Dr. Alexander, I should like to appoint you. I will hand you a book of Robert's Rules of Order, and you will be present, please, to assist the Chairman. (Applause.)

17. Constitution and By-Laws

(Sect. 14 continued)

Dr. Shapiro: Several of these by-laws that Hudson County proposes are substitutes for those of the committee and may I, therefore, ask the indulgence of the House of Delegates that our presentation of these be considered the first reading, so under New Business it will be considered the second, and lay over for a day? Otherwise I can't see how we can get two readings in today.

President Snedecor: I am afraid I cannot so rule. There will be a meeting of the House of Delegates tomorrow afternoon. It can lay over a day, and be brought up for final action on Thursday.

Dr. Shapiro: We will get the opportunity to have another hearing?

President Snedecor: Oh, yes. It is not my purpose to deprive you of an opportunity for hearing.

DR. REEVE L. BALLINGER (Hudson County): Inasmuch as there are so many changes in the By-Laws, may I ask that we have a copy made of those that we may at our leisure go over them before they are adopted?

PRESIDENT SNEDECOR: I think your request should be made or referred to the Chairman of that Reference Committee, and I am sure he will give it every consideration. As I told you before, a lot of those are proposed by me as your President with the thought of further improving the organization of the Society, and I do not have the purpose of pushing them over this year. I dont want it to be hasty and I wouldn't particularly move that they be adopted.

They must be thoroughly understood. No radical changes are intended. They are really in line with giving official adoption to the organization we now have; for instance, as an example, the Committee on Scientific Exhibits and the Committee on Woman's Auxiliary has no standing in our Constitution and By-Laws, so one provision is to give them official standing, and I will refer your request to Dr. Alexander.

18. REPORT OF SECRETARY

(Jour., April, p. 230)

PRESIDENT SNEDECOR: Next is the Report of the Secretary.

Secretary Morrison read his report, as follows:

To the President and Members of the House of Delegates:

This report was not published because it consists largely of statistics and obituaries. For the total figures we had to wait until the Official List was printed. Some amendments to our Constitution and By-Laws are being offered by me, and the necessity for these did not arise until after the reports of officers appeared in our Journal. The decision of the Judicial Council of the American Medical Association in the matter of the appeal of the Hudson County Medical Society from the decision of the Judicial Council, and the action of this House of Delegates will make further amendments necessary to clarify the powers delegated to the Board of Trustees, the Judicial Council, and to the House of Delegates. This decision will be read to you in a few moments.

We open today the 171st Annual Meeting of this venerable Society.

The House of Delegates this year consists of:

Line Officers and Trustees	21
Elected Delegates	213
Members of the Judicial Council	5
Fellows	11
A total of	250

An effort should be made by the officers of the component societies to see that their respective societies are represented here by a fuller delegation (and I call your attention to the fact that there are less than 100 of those present this morning).

Our total active membership today is 3225. This is a gain of 385 active members over last year.

We have also added 151 associate members. If we add these, it makes our total membership 3376, a gain of 532 members. This is a gain of nearly four times as many members as were ever added in any one year before.

We have lost by death seventy-nine members. Two more deaths have occurred since this report was compiled. So the hand of the Grim Reaper has been laid rather heavily upon us during the past year. (The average death rate is about thirty-nine.)

Among the most prominent of the deceased, whose counsel the House of Delegates will miss for years to come, were Dr. Harold Disbrow, a member of the Board of Trustees, representing the Fifth District. He was one of the outstanding physicians in his community. He had been ill with arthritis and complications for a year, and greatly regretted his inability to take part in the deliberations of the Board and of this House.

Dr. John F. Hagerty passed away early in February. He was President of this Society in 1931. He was a familiar figure in this House and his charming personality and florid delivery made him a beloved member. His demise was untimely, cutting short a brilliant career and leaving a gap in the profession in Essex County and in the State.

Dr. A. Haines Lippincott passed away very recently. He was President of this Society in 1932. He had served his component medical society brilliantly for many years, was a valued member of our Welfare Committee and served as its chairman the year prior to his election to the Presidency. He was one of the outstanding urologists in New Jersey.

Dr. John Nevin, of Hudson County; Dr. A. A. Stillwell, of Somerset County; Dr. J. Finley Bell, of Bergen County; Dr. Charles Gandy, of Cape May County; Dr. Martin Synnott, of Essex County; Dr. Theodore Corwin, of Essex County; and Dr. Eugene Way, of Cape May County, had all been delegates to this body at various times, and their demise is deeply regretted. Dr. Edgar J. Holden, of Essex County, also passed away during the year. He was probably the outstanding orthopedic surgeon in the State. So we have lost by death this year more prominent members than in the past five years together.

I would call the attention of the secretaries of the component societies to the fact that some component societies still persist in electing Trustees or Fellows to the position of Elected Delegates. The members of the Board of Trustees and the Fellows are members of this House of Delegates by virtue of their offices, and such elections deprive the component societies of another elected delegate.

Again I would call the attention of the various component societies to the fact that our Constitu-

tion and By-Laws distinctly state that members of the Nominating Committee must be *elected delegates.*

We are tightening up on our delegation to this House. Some component societies are represented here today by more delegates than they are entitled to, on a basis of their present membership. I shall introduce today amendments to the By-Laws providing that any elected delegate, absent from two consecutive meetings of this House of Delegates, except in cases of illness, shall forfeit his delegation.

Another amendment will be offered by me to the effect that in the future the representation of the component societies in this House shall be based on their membership in the last Official List, which is always in the hands of their officers at least a month in advance of the usual time of holding this meeting.

Cards similar to those sent to our delegates are being sent to the Secretaries of the component medical societies for the members of the Nominating Committee of the State Society. In the future no membr will be seated in the Nominating Com- no member will be seated in the Nominating Com- Secretary of his society, is presented to me here at the desk prior to 4 p. m. on the first day of the sessions of this House.

The compilation of the membership for the Directory of the Medical Societies of New York, Connecticut, and New Jersey reveals the fact that many physicians change their addresses without notifying my office. It is the constant effort both of my office and of the central office at Trenton, to have a perfectly accurate listing of our membership at all times. This cannot be done unless you or the Secretary of your society will notify us immediately of all changes in addresses, deaths, transfers, and of members moving out of the State.

It was discovered recently, that a component medical society had elected to active membership a physician residing in New York City, and who was not licensed by our State Board of Medical Examiners to practice in New Jersey. A study of our Constitution and By-Laws did not reveal any section forbidding this. So I am introducing, today, an amendment providing that any physician applying for membership in a component medical society, shall present to the Secretary of the society, or to the Membership Committee, his medical college diploma, and a certificate from our State Board of Medical Examiners permitting him to practice medicine in New Jersey.

Respectfully submitted,

J. B. Morrison, M.D.,

Secretary.

President Snedecor: I refer the report of the Secretary to Reference Committee B.

Action, Sect. 75 B.

19. Decision of the Judicial Council of the A. M. A.

(Minutes of Special Meeting of the House of Delegates, June 2, 1936, pages 60-72 of the Transactions)

Secretary Morrison: I have here the decision of the Judicial Council of the American Medical Association of the appeal by Hudson County. Shall I read it?

President Snedecor: A similar copy was received by the appellant in the case, the Secretary of Hudson County Medical Society, and I would request, if you will defer, that he be given the opportunity to read the decision. Is there objection from the House to the Secretary of Hudson County reading the decision of the Official Judicial Council of the A. M. A.

Dr. Norton: What was the request?

President Snedecor: The request is that the Secretary of the Hudson County Medical Society be permitted to read the decision of the Judicial Council of the A. M. A., which has been received by him, in place of having it read by the Secretary. This is done out of courtesy to the Secretary of the Hudson County Medical Society. Is there any objection? If not, I will give the floor to Dr. Thomas Brennock.

Dr. Thomas McG. Brennock: Mr. President and Fellow Delegates: The following decision from the Judicial Council of the American Medical Association was received by me on April 22, 1937.

Dr. Brennock read the decision, as follows:

DECISION OF THE JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION IN THE CASE OF THE APPEAL BY THE HUDSON COUNTY MEDICAL SOCIETY FROM THE DECISION OF THE JUDICIAL COUNCIL AND THE ACTION OF THE HOUSE OF DELEGATES OF THE MEDICAL SOCIETY OF NEW JERSEY.

As this case involves only the Constitution and By-Laws of the two societies and the procedures taken thereunder and is of primary interest only to those societies, no exhaustive analysis will be presented in this decision; but attention is directed to the following brief statements of the essential features of the controversy upon which the decision is based.

1. In strict conformity with the Constitution and By-Laws of the Hudson County Medical Society, the Secretary of the society prepared a ballot for election of officers. This ballot bore the names presented by the nominating committee and others nominated from the floor. Certain nominees from the floor and particularly Dr. Hugo Alexander, after copies of the ballot had been mailed to the membership as required, presented writ-

ten protest to the Executive Committee of the society demanding that the form of the ballot be changed. As the Executive Committee had no power to act but only to recommend to the Board of Directors at the next regular meeting and as definite time limits for the various procedures in elections are prescribed in the By-Laws which made it impossible legally to comply with the demands of the protestants, no action on the protest and demand of Dr. Alexander was taken by the Hudson County Medical Society so far as any evidence shows.

2. Dr. Alexander then made formal appeal to the Judicial Council of the Medical Society of New Jersey as follows: "Despite a written formal protest, the Hudson County Medical Society decided to permit and did permit the use of an improperly prepared ballot during the annual election Tuesday, October 1st, 1935."

"I hereby appeal to the Judicial Council from this decision and action." The Judicial Council heard Dr. Alexander's appeal, supported him in it and made certain orders concerning the personnel to fill the positions on the election ballot. As the society through its lawful body could not and did not hear. decide and take action, there was no basis for Dr. Alexander's appeal to the Judicial Council of the State Society. It necessarily follows that the Judicial Council acquired no jurisdiction over the controversy and having no jurisdiction its decision was of no effect.

3. The Hudson County Medical Society appealed to the House of Delegates of the Medical Society of New Jersey from the decision and orders of the Judicial Council and action, on the advice and recommendation of the Board of Trustees, dismissing the appeal and affirming the decision and action of the Judicial Council was taken, but as the Judicial Council had no jurisdiction and its decision was invalid, there was no cause to come before the House of Delegates and the House should have so held.

For the preceding reasons the Judicial Council of the American Medical Association sustains the appeal of the Hudson County Medical Association from the decision of the Judicial Council and the action of the House of Delegates of the Medical Society of New Jersey.

Among many irregularities occurring in the records of this case, the Judicial Council finds it pertinent to call attention to two actions seriously detrimental to the appellant and entirely unjustified by the Constitution and By-Laws of the societies:

1. The decision of the Judicial Council, after declaring the election held by the Hudson County Medical Society on October 5, 1935, illegal, proceeded to declare who the officers of that society should be. The Judicial Council of the state society has no authority to prescribe such officers. The selection of the personnel of its organization is the privilege and duty of the county society alone. It is beyond belief that any other body should presume to arrogate that privilege or duty to itself.

2. The By-Laws of the state society provide, "It (the House of Delegates) shall hear and finally determine all appeals taken from decisions of the Judicial Council." The procedure that was adopted cannot be reconciled with the requirements of the By-Laws of the State Society. In what lawful manner the Board of Trustees was endowed with jurisdiction over the controversy is not apparent. In its report, however, which was prepared before convening the special session of the House, the Board determined adversely the right of the Hudson County Medical Society to a hearing and, so far as the record shows, without giving the county society any opportunity to be heard. On the recommendation of the Board, the House of Delegates affirmed the decision of the Judicial Council without a hearing and with no opportunity for the County Society to be heard on its own appeal.

It also calls to attention that the Constitution of the State Medical Society provides for three divisions:

"1. The Board of Trustees is the Executive Body."

"2. The Judicial Council is the Judiciary Body."

"3. The House of Delegates is the Legislative Body."

Since the *Constitution* thus prescribes in broad outlines the functions of the House of Delegates, the Board of Trustees and the Judicial Council, any *By-Law* that attempts to confer legislative functions on the Judicial Council or on the Board of Trustees, or attempts to confer executive functions on the House of Delegates or Judicial Council, or attempts to confer judicial functions on the House of Delegates or Board of Trustees, would certainly seem to disrupt the scheme of organization contemplated by the Constitution. If the By-Laws may confer appellate judicial functions on the House of Delegates, as they do attempt to do, then the By-Laws may likewise completely rearrange the organization of the Society, the Constitution to the contrary notwithstanding.

If the Constitution of the state association says, as it does, that the House of Delegates is the *legislative body* of the association, then judicial functions may be conferred on the House of Delegates in only one way, that is by amendment to the Constitution. Until the Constitution is thus amended, any By-Law attempting to confer such functions is invalid.

GEO. EDW. FOLLANSBEE,
Chairman
LLOYD NOLAN
WALTER F. DONALDSON
EDWARD R. CUNNIFFE
JOHN H. O'SHEA

PRESIDENT SNEDECOR: If there is no objection, I will order the decision filed and published as part of the transactions of the Society. If there is objection to that procedure, I shall be glad to hear it. Hearing no objection, it is order that this decision of the Ju-

dicial Council of the American Medical Association be filed and made part of the transactions of this meeting.

20. Departed Members

Secretary Morrison: As an addenda to my report, I would suggest that as a token of respect to our departed eighty-one members, we rise for a moment.

President Snedecor: Gentlemen, I ask you to please rise in solemn respect for one moment with bowed heads and silence, in respect to those of our colleagues who have departed this life since our last meeting.

The House arose and observed a moment of silence.

21. Corrections to Reference Committees

(See Section 85)

President Snedecor: I should like to make two corrections with regard to Reference Committees. I have received two letters from Delegates, letters of regret, Dr. Frost, of Reference Committee A, and I appoint James P. Pregnall, Asbury Park, as a member of Reference Committee A; and one from Earl H. Snavely, of Reference Committee on Resolutions and Memorials, and I appoint Dr. W. E. Darnall, Atlantic City.

We cannot finish all of these reports at this time. They will come up at the next annual meeting.

Possibly we could take up one brief one. I will recognize Dr. Shapiro.

Dr. Shapiro: Dr. Williamson has been unable to attend and I am his alternate substituting for him.

President Snedecor: I received no notice of that, Dr. Shapiro, and I will take it upon myself to appoint another member to take the place of Williamson, Committee IV, under Miscellaneous Business.

(Nothing was referred to this committee.)

22. Honorary Membership

(Jour., April, p. 231)

President Snedecor: We will hear the Report of the Committee on Honorary Membership, Dr. Ely.

Dr. Ely: The Committee on Honorary Membership submitted the following report, which was printed in the Journal of April, page 231:—

The Chairman has consulted each member during the year. No nominations for honorary membership have been recommended since the last State Society convention.

Respectfully submitted,

Lancelot Ely, *Chairman.*

Dr. Lancelot Ely: There being no further action of the Committee, the Report of the Committee is hereby submitted for the Transactions.

(See Sect. 25a)

23. Publication Committee

(Original Report April Journal p. 232)

We will have time for the Report of the Publication Committee, Dr. Henry C. Barkhorn, Chairman.

. . . Dr. Barkhorn presented the Supplemental Report of the Publications Committee as follows:

Supplementary Report of the Publication Committee

Since the middle of March when the report of the Publication Committee was written, the annual reports of the other officers and committees have been received. These supply abundant evidence of appreciation of the policy of the Publication Committee that The Journal shall recognize the excellent work done by the county societies and their members.

Further evidence of the effectiveness of the work of the officers and committees of the State Society is contained in the Bulletins of the County Societies. Esepecially noteworthy are the favorable comments on the work of the Welfare Committee, on which every county society is represented. Circles of influence emanating from these local leaders have impinged first upon the county societies, and secondly on their individual members, so that The Journal is no longer the organ of The Medical Society of New Jersey, but it has become the organ of the county societies and their individual members.

Further evidence of the increasing response of the members is the unexpectedly great demand for advertising space in the April Journal, making it necessary to refuse some applicants for space.

It has been the policy of the Publication Committee to report the proceedings of the committees of the State Society in the form of word pictures, rather than to print the stenographic reports of everything that was said and done. The formal minutes of the committees are on file in the Executive Offices; but a summary of the debates and the conclusions reached is printed in The Journal, with the result that the officers and committeemen consult The Journal rather than the files. The value of the reports in The Journal is greatly enhanced by the practice of preparing and printing cross-references to former reports, so that a complete picture of all the developments of activities can readily be obtained.

It has also been the policy of the Publication Committee to refer to back numbers of The Journal, and to its predecessor,—the annual volume of Transaction,—in order to trace the development of the several phases of the state organization from their beginning. An example of this study is the brief history of the development of the Board

of Trustees from the year 1816, as recorded on page 150 of The Journal of March.

The Publication Committee plans to continue to expand the present scope of The Journal so that it will be the accepted organ of every county society and of every member. In carrying out this policy, it also approves the Bulletins of the county societies, and offers every possible assistance to their development.

Respectfully submitted,

Henry C. Barkhorn, *Chairman,*
Edward J. Ill,
Frank J. McLoughlin,
Spencer T. Snedecor, *Ex-Officio*
J. Bennett Morrison, *Ex-Officio*

President Snedecor: The report of the Publication Committee is referred to Reference Committee C.

Action, Sect. 76 A.

President Snedecor: I cannot stress sufficiently the importance of the work of the Reference Committees and the Delegates who compose them. I hope you will give most careful consideration to the annual reports. A number of the reports have not been read this morning. They cannot be read until the session tomorrow afternoon. I ask the Reference Committees to consider carefully within this time the reports as published, and possibly speak to the Chairmen to see what the supplemental reports are, so they can proceed intelligently with their work.

President Snedecor: The next meeting of the House of Delegates will be at twelve-thirty tomorrow, to consider the Election of Officers.

Dr. Shapiro: Oh, I was told we would be able to introduce these amendments.

President Snedecor: I am sorry. I am afraid you misunderstood me. I said that New Business would come up tomorrow afternoon and you would be permitted to introduce them then.

Dr. Shapio: The Constitution distinctly states that tomorrow shall be given over to the Election of Officers, not to New Business.

Dr. Quigley: Mr. President, I think perhaps I might help. I think a motion should be made to adjourn for other business than the business of electing officers, which is the only order of business tomorrow. I think a motion should be made to adjourn to a denite time tomorrow for the continuation of reports and new business.

President Snedecor: Which is set in the program, Dr. Shapiro, for two-thirty tomorrow afternoon.

Dr. Shapiro: You ruled before I would have the opportunity of reading them. I have not had—

President Snedecor: I beg your pardon, I said there would be a meeting of the House of Delegates tomorrow afternoon at which you would be permitted to introduce those, and they would be voted on at the last meeting on Thursday afternoon. That conforms to the Constitution and By-Laws.

Dr. Alexander: "Chapter XV—Amendments. These By-Laws may be amended at any annual meeting of The Medical Society of New Jersey by a two-thirds vote of the members present, provided that at least fifty members are present; and, provided further, that the amendments shall have been submitted to the Committee on Constitution and By-Laws, and shall have been twice read in open meeting and laid upon the table for one day."

That substantiates what you said, Mr. President. The amendments have been submitted to the Chairman of the Committee on By-Laws. We adjourn till tomorrow, and any delegate can propose an amendment at the meeting tomorrow. It will be read twice and laid over to the following day, when it will finally be acted upon.

President Snedecor: Gentlemen, are you ready for a motion that this Society's House of Delegates adjourn until tomorrow afternoon at two-thirty for continuation of reports and New Business?

Upon motion regularly made and seconded it was voted to adjourn until two-thirty on Wednesday, April 28, 1937, for the continuation of reports and New Business.

The session adjourned at one o'clock.

WEDNESDAY NOON SESSION, APRIL 28, 1937

The second session of the House of Delegates convened at twelve forty-five o'clock, President Snedecor presiding.

24. Appreciation of Secretary Morrison

(See Sect. 13)

President Snedecor: Gentlemen, I will call this meeting to order and, according to the Constitution and By-Laws, the Report of the Nominating Committee, and the Election of Officers, standing Committees, Delegates to the American Medical Association, and other medical organizations shall be the first order of business of the Society in the afternoon of the second day of the Annual Meeting.

The Committee on Arrangements anticipated this meeting would simply be for the Election of Officers and would continue the meeting at two-thirty for other business. If you wish that order changed, it will take a special motion.

Dr. Morrison, I should like to recognize you.

Secretary Morrison: This morning the Trustees announced their policy that all the records of the Secretary's office should be transferred to the Executive Offices in Trenton; and that the routine clerical and administrative duties shall be performed by the Executive Officer and his clerical assistants.

There was a heart-to-heart talk among the Trustees in regard to their attitude toward your Secretary. Member after member, to the number of sixteen, stood up and attested their high regard for me, and the remarks of many of them, expressing their warm friendship, touched me very deeply.

I was made to see definitely and clearly that the proposed amendment doing away with the office of the Secretary as a paid officer was done wholly in the interests of the State Society.

Before Dr. Wilkes was appointed Executive Officer, my office was the most important one in the State Society. Then, when Dr. Snedecor formed his cabinet, the members of that cabinet traveled all over the state visiting each County Society at least once, and several of the larger County Societies two or three times. There was no further necessity for me to cover the state at an extra expense to the State Society, so this year you have not seen me at your meetings.

Now, since Dr. Wilkes' office has been established in Trenton, there has been a duplication of work and effort on the part of both of us because of conflicts. I am perfectly well satisfied that the work of the Secretary in the future should revolve around the office in Trenton. If the Secretary had a desk there, and the services of a stenographer, his utility to the Society would be increased a hundredfold, so I asked the Nominating Committee last night to see that my name was not presented, and I am asking the House of today not to name me from the floor.

I had a salary of $1500 a year, an expense account of a thousand dollars. Frequently that expense ran up to $1150, and the Treasurer always paid it. The balance in excess of the appropriation of a thousand dollars was paid out of the unexpended funds of some other committee, so, in doing away with the office of Secretary as a paid office, the Society will save at least a thousand dollars a year.

In retiring I want to thank this House of Delegates for the confidence the members have reposed in me by electing me to this office year after year for fifteen years, and, in retiring to the ranks of a regular member, I assure you of my deep and continued interest in the welfare of the Medical Society of New Jersey.

The assembly arose and applauded.

President Snedecor: Dr. Morrison, as President of the Society, I feel that I should extend to you a few brief words. The sentiment of these members you see before you. I know how they feel. I know how they regard you. You have been a trusted and honored servant of this Medical Society for many years. How many?

Secretary Morrison: Fifteen.

(Dr. Morrison was first elected on June 22, 1923 [Jour., Oct. 1923, p. 368].—Editor's note.)

President Snedecor: Fifteen years. You have served faithfully and you have served well, and I wish that it be inscribed in the records of this Society that this body of Delegates extends to you a most sincere vote of appreciation for your services to the Society. Do I hear such a motion?

Many Delegates offered the motion in an outburst of applause, and as many seconded the motion, which was put to a vote and was carried unanimously; after which the assembly again arose and applauded.

Secretary Morrison: Mr. President and Members: I can only say again that I thank you.

25. Election of Officers

President Snedecor: Now, gentlemen, the order of busiess is the Report of the Nominat-

ing Committee. I will recognize the Chairman of the Nominating Committee, our Past President, Dr. Newcomb.

DR. MARCUS W. NEWCOMB: The Secretary of the committee, Dr. Downs, has the report and will read it; and after that, I should like to say a few words.

Dr. Elwood E. Downs read the report of the Nominating Committee, as follows:

REPORT OF NOMINATING COMMITTEE

A meeting of the Nominating Committee was held on Tuesday evening, April 27, 1937, at 8:30 p.m., with Dr. Marcus W. Newcomb presiding, and twenty-two members present at roll call.

The committee wishes to submit the following report of its nominations:

President-Elect, William J. Carrington
First Vice-President, E. Zeh Hawkes
Second Vice-President, Watson B. Morris
Secretary, Alfred Stahl
Treasurer, Elias J. Marsh

Trustees (for term expiring in 1940):
J. Howard Hornberger
Wells P. Eagleton
Andrew F. McBride

Judicial Council, Barclay S. Fuhrmann

Delegates to A. M. A.:
Wells P. Eagleton (for the unexpired term of Dr. Hagerty to 1938)
Andrew F. McBride E. R. Mulford

Alternate Delegates, A. M. A.:
Spencer T. Snedecor Hilton S. Read

Committee on Publication, Edward J. Ill

Committee on Program and Arrangements, John W. Gray

Dr. Londrigan, of Hudson County, called the attention of the Nominating Committee to the fact that Dr. William J. Sweeney, of Hudson County, was illegally nominated and elected Councilor of the Second Judicial District. Dr. Londrigan claimed that Dr. Sweeney was not a delegate of his component society at the time he was elected, and quoted the Constitution, as follows:

Article VII—Councilors. The House of Delegates shall organize five (5) Councilor Districts within the State. This Society shall elect one (1) Councilor from among the delegates of each such district; and these elected Councilors, collectively, shall constitute the Judicial Council.

Dr. Sweeney's term as delegate was from 1931 to 1934. He was elected Councilor in 1935.

On motion of Dr. Miller, which was seconded by Dr. Watkins, the Secretary was instructed to present the above matter to the House of Delegates.

MARCUS W. NEWCOMB, *Chairman.*
(Election of Councilor, Sect. 86)

DR. NEWCOMB: Dr. Londrigan brought up this question before the Nominating Committee and requested the Nominating Committee to declare the office vacant, and we didn't think that was within our power. We thought that was business for the House of Delegates and the House of Delegates only.

DR. JOSEPH F. LONDRIGAN: Please do not give the impression to this House of Delegates that I asked the Nominating Committee to declare that.

PRESIDENT SNEDECOR: Dr. Londrigan, Dr. Newcomb has the floor.

Cries of "Out of order".

DR. LONDRIGAN: I am not out of order. I did not say to declare it vacant. I said "The By-Laws", not "The Nominating Committee".

DR. NEWCOMB: Dr. Londrigan said he wanted us to nominate someone before the House of Delegates declared the office vacant, which we decided was not within our power. He said that by Dr. Sweeney having his term as a delegate expire, it having expired in 1934, and he was elected in 1935, that he was elected illegally, and that automatically vacated the office, but we had no power to interpret the By-Laws that way. There weren't any of us lawyers, and nobody was able to interpret the By-Laws. While they say that the Councilor shall be a Delegate, it seems to me, as you saw in our resolution, that it is for this House of Delegates to decide, and it is for the County of Hudson to prove that the term of its Delegate expired in 1934.

I have an affidavit here from Dr. Brennock, the Secretary, sworn to, which says that his term expired in 1934, and that he was not a Delegate in 1935, and he says that he looked up the minutes of the Hudson County Medical Society. We are simply referring it to the House of Delegates, because we decided that we had no action in the matter.

PRESIDENT SNEDECOR: Thank you, Dr. Newcomb.

Mr. Secretary, may I ask you if there is a vacancy at this time in the Councilors from the Second District?

SECRETARY MORRISON: Second District, no.

PRESIDENT SNEDECOR: Then the Chair rules, gentlemen, that since there is no vacancy at this time in the Second Judicial District, the nominations as reported by the Nominating Committee complete the list of officers. It is our opinion that in order to remove an officer of this Society who has served two years, it is necessary to bring it before the House of Delegates under New Business, and in the proper way, and not before the proper Election of

Officers prescribed by the Constitution and By-Laws.

You have heard the nominations as given.

Dr. George Kerdasha: May we bring that up under New Business? Can we elect——

President Snedecor: The Chair rules that that shall properly come up under New Business; if the office is declared vacant, I believe it is the prerogative of this body then to elect a successor.

Dr. Londrigan: This is only Election of Officers at this session and no other business can be transacted.

President Snedecor: I beg your pardon, Dr. Londrigan.

Dr. Londrigan: I say it for information. I am only asking. It says on the program—this is an office of the State Society.

President Snedecor: If you would listen to my reading of the By-Laws, it says: "This shall be the first order of business on the afternoon of the second day of the Annual Meeting." Then I added that the committee had arranged that this be simply for the Election of Officers, and that such other regular business continue at two-thirty.

Dr. Londrigan: After the officers are elected, we can't elect any officers till two-thirty?

President Snedecor: Oh, yes, if the House so orders.

Now I am going to read the Report of the Nominating Committee, and I will ask, as I go down the list, if there are any nominations from the floor. President-Elect, William J. Carrington. Do I hear any nominations from the floor?

Dr. David B. Allman: It gives me great pleasure to move that the nominations be closed and that the Secretary cast one ballot for Dr. William J. Carrington, as President-Elect.

Dr. Londrigan: I second the motion.

Secretary Morrison: The ballot is cast, Mr. President.

President Snedecor: The next nomination is of First Vice-President, Dr. E. Zeh Hawkes. Are there any nominations from the floor?

Dr. H. Burton Walker: I move that the nominations be closed and that the Secretary be instructed to cast one ballot for the election of Dr. E. Zeh Hawkes as First Vice-President.

Dr. James F. Norton: On behalf of Hudson County delegation, I rise to second the nomination of Dr. Hawkes.

Secretary Morrison: The ballot is cast, Mr. President.

President Snedecor: The ballot has been cast for the First Vice-President, Dr. E. Zeh Hawkes.

The Second Vice-President, Dr. Watson B. Morris—do I hear nominations from the floor?

It was moved by Dr. Elmer P. Weigel, seconded by Dr. Norman W. Burritt, that the nominations be closed and the Secretary be instructed to cast one ballot for Dr. Watson B. Morris as Second Vice-President. The Secretary reported that the ballot had been cast.

President Snedecor: The Chair will have a vote whenever it is called for. The next nomination is for Secretary, Dr. Alfred Stahl. Do I hear any nominations from the floor? If not, the Chair will entertain a motion that the nominations be closed and that the Secretary be instructed to cast a ballot for Dr. Stahl as Secretary.

The motion was made by Dr. Marcus W. Newcomb and seconded by Dr. Edward W. Sprague. The Secretary reported that the ballot had been cast.

President Snedecor: It is so ordered. Nominations for Treasurer, Elias J. Marsh. Do I hear any nominations from the floor?

I will entertain a motion.

It was moved by Dr. John H. Irwin, seconded by Dr. Christopher C. Beling, that the nominations be closed and that the Secretary be instructed to cast one ballot for Dr. Elias J. Marsh as Treasurer. The secretary reported that the ballot had been cast.

President Snedecor: For Trustees, Dr. J. Howard Hornberger, of Burlington, as Trustee from the Fourth District. Do I hear nominations from the floor?

It was moved by Dr. Marcus W. Newcomb, and seconded by Dr. Alfred Stahl, that the nominations be closed and the Secretary be instructed to cast one ballot for Dr. J. Howard Hornberger as Trustee from the Fourth District. The Secretary reported that the ballot had been cast.

President Snedecor: Dr. Wells P. Eagleton, as Trustee to succeed himself. Do I hear any other nominations?

It was moved by Dr. Edward W. Sprague, and seconded by Dr. Frederic J. Quigley, that the nominations be closed and that the Secretary be instructed to cast one ballot for the election of Dr. Wells P. Eagleton as Trustee, to succeed himself. The Secretary reported that the ballot had been cast.

President Snedecor: Nominations for Trustee, Dr. Andrew F. McBride, to succeed himself. Are there any nomination from the floor? I hear no nominations from the floor. On what question do you wish to speak, Dr. Londrigan?

25 A. Honorary Members

Dr. Londrigan: I wish to speak on the question of Dr. McBride's being a Trustee, and call to your attention and the attention of the House of Delegates, page 6 of the Constitution: "Honorary Members". It states that honorary members shall have the privileges of members, "But shall not be members of the corporate body"; and inasmuch as he is an honorary member and not a member of the corporate body, he is not eligible to the office of Trustee. I am calling that to the attention of the House of Delegates to use their own judgment.

President Snedecor: Thank you, Dr. Londrigan.

Dr. Londrigan: You are welcome.

President Snedecor: The matter has been brought to the attention of the House of Delegates that since Dr. Andrew F. McBride is an honorary member of this Society, he cannot be a member of this corporate body and therefore is not eligible for election as Trustee. The Chair will ask in this question the advice of the Committee on Honorary Membership. I will recognize Dr. Ely.

Dr. Lancelot Ely: Mr. President and Members of the House of Delegates: The matter was called to the attention of the Committee (Sect. 22). If we do not approve of this action, it will affect two members of our State Society, Dr. Eagleton, and Dr. McBride. In reading over the Constitution as quoted by the former speaker, "They shall have all the privileges of members, but shall not be members of the corporate body", I believe it was the intention of the committee who drew up this Constitution and By-Laws, that it was meant mostly for members of other State Societies, other than our State Society.

These two valuable members, Dr. Eagleton and Dr. McBride, are active members of our State Society. They are also Fellows of the State Society, which comprises to a certain extent members of the corporate body, and, by their position as Fellows, they have the right to sit in as active members of the corporate body.

We would have to change our Constitution in some way, or interpret this last paragraph of the "Honorary Members", if we wanted to extend to members of our State Society the privileges of Honorary Members. Both of these men, as you know, have done outstanding work as members of our State Society, in many ways, and it was on account of that position they were placed on the honorary list, and it is the committee's opinion that they can still be members of the corporate body and be given the honor of being honorary members, as long as they pay their dues. It is a question of interpretation from a legal standpoint.

Dr. Quigley: May I add something on this matter?

President Snedecor: I would rather not at this time. The Chair will rule on the advice of the Committee on Honorary Membership that since Dr. McBride is a Fellow of the Society, he is a member of the corporate body; having paid his dues, he is an active member in good standing, and is eligible for election as Trustee to this Society. If there is any question about his holding two positions, Dr. McBride has the privilege of resigning as Honorary Member.

Gentlemen, are there any other nominations?

Dr. Maurice Shapiro: Mr. Chairman, as we proceed, I want to go on record that we do not accept the ruling of the Chair.

25 B. Election of Officers, Continuing Sect. 25

Dr. Henry H. Kessler: That nomination was not moved yet, and I should like to take this opportunity of moving that the nominations be closed and that the Secretary be instructed to cast the ballot for Dr. Andrew F. McBride as Trustee.

The motion was seconded by Dr. Lancelot Ely. The Secretary reported that the ballot had been cast.

President Snedecor: For the Judicial Council, Dr. Barclay S. Fuhrmann. Do I hear any nominations from the floor? Hearing none, I will entertain a motion.

Dr. Lancelot Ely: I move that the nominations be closed and that the Secretary be instructed to cast one ballot for the election of Dr. Barclay S. Fuhrmann to the Judicial Council.

The motion was seconded by Dr. Frank G. Scammell. The Secretary reported that the ballot had been cast.

President Snedecor: Delegates to the American Medical Association; first, the unexpired term of Dr. Hagerty, to 1938, Dr. Wells P. Eagleton is proposed. Are there any other nominations?

It was moved by Dr. Frederic J. Quigley, seconded by Dr. Alfred Stahl, that the nominations be closed and that the Secretary cast one ballot for Dr. Wells P. Eagleton as Delegate to the American Medical Association, to fill the unexpired term of Dr. Hagerty, to 1938. The Secretary reported that the ballot had been cast.

President Snedecor: Next is Dr. Andrew F. McBride, as a Delegate for full term to the American Medical Association. Are there any

nominations from the floor? Again, not hearing any, I will entertain a motion.

It was moved by Dr. Watson B. Morris, and seconded by Dr. David B. Allman, that the nominations be closed and that the Secretary be instructed to cast one ballot for the election of Dr. Andrew F. McBride as full-term Delegate to the American Medical Association. The Secretary reported that the ballot had been cast.

President Snedecor: Next is Dr. E. R. Mulford, as Delegate to the American Medical Association. Are there any nominations from the floor?

It was moved by Dr. Newcomb, and seconded by Dr. Hilton S. Read, that the nominations be closed and that the Secretary be instructed to cast one ballot for the election of Dr. E. R. Mulford as Delegate to the American Medical Association. The Secretary reported that the ballot had been cast.

President Snedecor: Now for committees. Committee on Publication, Dr. Edgar F. Ill——

Several Members: Edward J. Ill.

President Snedecor: Mr. Secretary of the Nominating Committee, would you please straighten us out as to which Dr. Ill was nominated? This reads Dr. Edgar F. Ill.

Dr. Downs: Edward J.

President Snedecor: The nomination is of Dr. Edward J. Ill. Do I hear any other nominations?

It was moved by Dr. Frank A. Bien, and seconded by Dr. William A. Tansey, that the nominations be closed and that the Secretary be instructed to cast one ballot for the election of Dr. Edward J. Ill, Committee on Publication. The Secretary reported that the ballot had been cast.

Dr. David B. Allman: Before you turn the page, I should like to move that the nominations be closed for Alternate Delegates to the A. M. A., and that the Secretary cast one ballot for Dr. Spencer T. Snedecor and Dr. Hilton S. Read, for Alternate Delegates.

President Snedecor: Thank you. There is one more committee to be taken care of, Dr. John W. Gray for Committee on Program and Arrangements. Do I hear any nominations from the floor?

It was moved by Dr. Asher Yaguda, and seconded by Dr. E. LeRoy Wood, that the nominations be closed and that the Secretary be instructed to cast one ballot for the election of Dr. John W. Gray for the Committee on Program and Arrangements. The Secretary reported that the ballot had been cast.

President Snedecor: The Chair has skipped over the Alternate Delegates to the A. M. A. First is Dr. Spencer T. Snedecor. Do I hear any nominations from the floor?

Dr. David B. Allman: I move the nominations be closed and the Secretary cast the ballot.

The motion was seconded by Dr. H. Burton Walker. The Secretary reported that the ballot had been cast.

President Snedecor: Alternate Delegate to the American Medical Association, Dr. Hilton S. Read.

It was moved by Dr. David B. Allman, and seconded by Dr. Joseph F. Londrigan, that the nominations be closed and that the Secretary be instructed to cast one ballot for Dr. Hilton S. Read as Alternate Delegate to the A. M. A. The Secretary reported that the ballot had been cast.

Dr. Marcus W. Newcomb: Point of order. On all these motions for the Secretary to cast the ballot, there was no vote on the motion. To have the record clear, you ought to vote on all of this at one time, because you have no vote on any one of these men that the nominations have been closed and that the Secretary cast the ballot.

President Snedecor: The Chair will entertain a motion.

Dr. Joseph F. Londrigan: I move that all of the candidates put in by the Nominating Committee shall be elected by this House of Delegates.

Dr. David B. Allman: I hate to take issue with Dr. Newcomb, but all you have to do is count the Secretary's ballots.

President Snedecor: To get it in the record, I will entertain Dr. Londrigan's motion that all of the candidates designated by the Nominating Committee be declared elected and that the Secretary be instructed to cast the ballot for the whole slate.

The motion was seconded by Dr. Sprague, was put to a vote, and was carried.

Secretary Morrison: The ballot has been cast.

President Snedecor: The Chair will rule that the Election of Officers is over.

Now, I would also rule, Dr. Londrigan, that if you wish to continue with business at this session, it will require a special motion of the House.

26. Protesting the Election of an Honorary Member as Delegate to the A. M. A.

(Sects. 22 and 25 A)

Dr. Londrigan: May I have the privilege of the floor? I want to get myself straightened

out with a few men who are very dear friends of mine.

Certainly Dr. Eagleton, in the State Medical Society, has done grand work, in all of the years that I have been connected with it. Dr. Andrew F. McBride was my superior, and he has done a lot of work for the State Medical Society. He is my friend, as Dr. Eagleton is my friend, and when I got up here today and made a protest in reference to the interpretation of these By-Laws, it was not because I disliked Dr. Eagleton or Dr. McBride. It was not because I did not think that the work that they have done for the Medical Society has been splendid. I did not write the By-Laws. I did not write the Constitution, but in our By-Laws and in our Constitution, it specically is stated that a member who is now an honorary member is not a member of the corporate body.

The intention of those who wrote that I do not know. Dr. Ely made a speech and told you it is a question of interpretation. That is all it is with me, and that is *all* it is with me; and so far as having the services of Dr. Eagleton and Dr. McBride on the Board of Trustees, I would not want to see them stopped. They have been very earnest, and very honest in their efforts to advance the medical profession in the State of New Jersey. On the other hand, we must know what the correct interpretation is, and, inasmuch as the State Society cannot interpret those By-Laws and Constitution, it is my duty as a member of the State Society to bring to the American Medical Society the interpretation of these By-Laws, and that is what I propose to do. I am not doing this with any ill feeling toward Dr. McBride or toward Dr. Eagleton.

That is the reason that was brought before the Nominating Committee last night, that inasmuch as my good friend, Andrew F. McBride, is not a member of the corporate body, he is not eligible to hold office; and I want to say to you, Mr. President, that as to Dr. Eagleton and Dr. McBride, I consider them my friends, worthy, wonderful members of the State Society.

President Snedecor: Am I to understand that this is not simply a word of explanation, but a notice of an appeal by you to the American Medical Association, in protest of the election which has just been held?

Dr. Londrigan: That is correct.

President Snedecor: An appeal by Dr. Joseph F. Londrigan as to the election of Dr. Andrew F. McBrdie.

Dr. Londrigan: It is for the interpretation of the By-Laws, and not as to the election of Dr. McBride.

Dr. Quigley: If a protest is to be made of the interpretation of the Constitution, to go to the American Medical Association, I simply would like to furnish the last speaker with a little further information which he may also transmit to the A. M. A.

The Medical Society of New Jersey is a legally incorporated society. It is an old society, as you know. It was first incorporated or organized in 1766. The present charter, which was granted by Act of the Legislature, was granted in 1864 or 1865. Now, even assuming there was anything in the Constitution which was susceptible of interpretation such as has been given by some of the delegates from Hudson County, the Constitution must be in conformity with the charter.

Now, the corporated body of this Society by charter—permit me to read—speaking of the Constitution, of the members that constitute the corporate body, it states: "'The Medical Society of New Jersey' shall continue to be a body corporate and politic, in fact and in name, and shall and may have and use a common seal, and alter the same at their pleasure; and that the said society shall be composed of delegates (not less than three), chosen by and from each of the district or county societies, which now are, or which under the authority of the said society may be hereinafter instituted; the officers for the time being shall be ex-officio members of the said society, independently of the authority of delegation; and all persons who shall have been, or may hereafter be, Presidents of the society, shall rank as Fellows, and be entitled to all the privileges of delegated members."

Dr. Londrigan: He was a Fellow. Then he was elected an Honorary Member, and that knocks out his fellowship.

President Snedecor: On this discussion there is a point of clarity about the Constitution and By-Laws, and I commend that point to two committees to study and see if it needs clarification to the Committee on Honorary Memberships and the Committee on Constitution and By-Laws. You will please take up that point.

Is there any other business concerned with this election? At this time, then, we will adjourn for continuation of business from yesterday morning, at two-thirty this afternoon and we will proceed as rapidly as possible with reports and get on to new business.

The session adjourned at 1:25 o'clock.

WEDNESDAY AFTERNOON SESSION, APRIL 28, 1937

The meeting convened at 2:40 o'clock, President Snedecor presiding.

27. JUDICIAL COUNCIL

(Jour., April, p. 235)

PRESIDENT SNEDECOR: Gentlemen, I declare this meeting of the House of Delegates open. We will continue with the reports of committees, where we left off yesterday morning. We were on reports of committees and officers, and the next is the Report of the Judicial Council. Is Dr. Beling here?

(There was no reply.)

I will refer the Report of the Judicial Council to Reference Committee "B".

Action, Sect. 75 C.

PRESIDENT SNEDECOR: Perhaps I should say something about the sessions this afternoon and tomorrow. We have allowed this afternoon for a meeting of the House of Delegates, at which we must complete the reading of all reports and resolutions and New Business. Tomorrow at twelve-thirty will be the final meeting of the House of Delegates and there can be no New Business introduced without unanimous consent. That means that there is a great deal of work to be done this afternoon. I ask your coöperation and I shall take some privileges, as the Chair, in the interests of the Medical Society, in hastening our work.

I will ask all of you to be brief in your remarks, and quite to the point. Reports from committees I wish to be held down as briefly as possible. Let's get along and take care of everything that we can without signing off anyone who has a word to say.

If the Chairmen of these committees are not here as I call for them, and they come in later, we will try to find opportunity to give them a word.

28. INTRODUCING DR. BISHOP

PRESIDENT SNEDECOR: At this time I should like to call the attention of the House to the presence of an illustrious visitor, President-Elect of the Medical Society of Pennsylvania, Dr. Frederick J. Bishop. (Applause.) Dr. Bishop, I wish to extend to you the privileges of the floor if there is no objection from the House.

DR. FREDERICK J. BISHOP: Mr. President and Members of the House of Delegates of The Medical Society of New Jersey: First, Mr. President, I have no apology or really cannot make any apology for the absence of the President of our State Society any more than that he commandeered me to come here and say "How do you do?" to you, which I most sincerely do.

Certainly the Medical Society of the State of Pennsylvania extends sincere felicitations to The Medical Society of New Jersey. I can't say "a sister society", because the difference in the ages must make you the grandmother of the Pennsylvania Society. I am glad to be here. I expect to learn something. I don't expect to tell you anything. I expect to learn something and probably take something home that I can use next year, after October; and incidentally, may I extend to you a most cordial invitation to visit our annual meeting, only across at Philadelphia, October 4-7, this year?

I thank you very much! (Applause.)

PRESIDENT SNEDECOR: We are very glad to have you with us, Dr. Bishop.

29. COMMITTEE ON MEDICAL DEFENSE

(Jour., April, p. 236 and p. 281)

PRESIDENT SNEDECOR: Is Dr. Beling here yet? If not, we will have the Report of the Committee on Medical Defense. Well, that is also under Dr. Beling, as Chairman, and he is not here, so I will assign the reports of those two, then; the Committee on Medical Defense is referred to Reference Committee "D" (Sect. 77); the Report of the Judicial Council is referred to Reference Committee "B" (Sect. 75).

(The following Supplemental Report of the Committee on Medical Defense was received after the Annual Meeting.—The Editor.)

The committee has already rendered a full report which was published in the April Journal, p. 236. According to the Official Report, the membership of the Society is 3376 including the associated members; and of this number 2728 are protected by insurance under the Special Professional Liability Contract of the Society. This is the largest number of physicians insured, and by excluding the physicians in the employ of State and municipal government the number insured would be approximately 90 per cent of the total membership. Last year there were 200 delinquents who were not on the Official List. This year the number of delinquents has been reduced to ninety-five, indicating that more doctors have taken the precaution to protect their insurance by keeping in good standing.

The following table sets forth the number of members insured by counties:

	Membership	Insured
Atlantic	115	88
Bergen	237	228
Burlington	55	40
Camden	173	143
Cape May	23	18
Cumberland	55	38
Essex	875	721
Gloucester	39	34
Hudson	422	377
Hunterdon	21	15
Mercer	223	170
Middlesex	121	114
Monmouth	122	106
Morris	88	85
Ocean	25	18
Passaic	274	208
Salem	20	12
Somerset	55	27
Sussex	20	19
Union	291	250
Warren	30	23
	3376	2728

Among the prominent causes of complaints against doctors reported during the past year were five cases of burns caused by x-rays, diathermy and electrical burns; two cases of forcible confinement in mental hospitals; and two cases of broken needles and hypodermic injections. Among the other causes were operation without permission, clot in vein due to injection, dinatrophenol poisoning with loss of vision, operation for strabismus with subsequent loss of eye, hayfever injections, improper treatment of fractures, and an error made in prescription.

Respectfully submitted,

Committee on Medical Defense

C. C. BELING, *Chairman.*

30. REPORTS OF COUNCILORS

(Jour., April, p. 237)

We will go on to the Report of the Councilors, Drs. Beling, Sweeney, Scammell, and Fisher.

DR. FRANK G. SCAMMELL: The Report of the Councilors is in the hands of the Secretary, Dr. Fisher. I just can't memorize his report at this time, therefore I would ask you to excuse me from making the Report of the Councilors.

PRESIDENT SNEDECOR: The Chairman wished to give you an opportunity to report individually.

DR. ULMER: Dr. Fisher will be here later to give the report.

31. COMMITTEE ON INSURANCE

(Jour., April, p. 238)

PRESIDENT SNEDECOR: Committee on Insurance, report by the Chairman, Dr. Pinneo.

DR. FRANK W. PINNEO: This is the Report of the Committee on Insurance.

Dr. Pinneo presented the written report, as follows:

ELEVENTH ANNUAL REPORT OF THE COMMITTEE ON INSURANCE

This year we report further developments in both lines of insurance in our care.

1. On health and accident insurance, we have just received a new offer from the National Casualty Company further liberalizing the conditions of coverage in illness without increase of premium.

2. On automobile insurance free service in prosecuting your claims against the "other party" in an accident which service is not covered in any insurance policy. This service in one year brought to our members collections which equalled the whole State Society dues at $13.00 each for 282 members or $1.30 each for the whole membership.

Further we emphasize other points, all of which are covered in our report as published.

THE COMMITTEE.

April 27, 1937.

This report covers eleven months from March 1, 1936, to February 1, 1937, a month less than the year because of the early date of this convention.

THE ACCIDENT AND HEALTH INSURANCE

This is a group policy with the National Casualty Company and is the very contract originally negotiated by us years ago after a thorough study of many standard policies with special features adapted to the needs of the average doctor's life and at a premium so reasonable all our members would want to pay. And these features have been added to; e. g., covering travel by air, originally not done, and increasing the time for disability not house-confining—all without any increase of premium. Other advantages we are keenly watching to add as fast as the number taking the policy increases to warrant it. There are 272 policyholders distributed as follows:

IN EACH COUNTY

Atlantic	5
Bergen	30
Burlington	5
Camden	18
Cape May	5
Cumberland	4
Essex	73
Gloucester	6
Hudson	18
Hunterdon	4
Mercer	16
Middlesex	7
Monmouth	9

Morris	16	
Ocean	3	
Passaic	15	
Salem	3	
Somerset	5	
Sussex	2	
Union	25	
Warren	3	
		272

This includes an increase for the period of 23 and a decrease of 25.

Distributed by Age Groups

Ages under 50	167	
51 to 60	66	
61 to 65	26	
66 to 70	13	
		272

Claims Paid

Ages under 50—23 claimants	$2,466.04	
50 to 60— 9 claimants	2,485.68	
60 to 65— 2 claimants	121.43	
66 to 70— 5 claimants	778.56	
		$5,851.71

These claims ranged from $25.00 to $1,374.99 each.
Gross premiums received in the eleven months, $15,902.64
Loss ration, 37 per cent, which will be increased in closing pending cases.

For accidents, benefits are for fifty-two weeks' total and twenty-six weeks' partial disability, and for travel accident the indemnity is doubled.

For illness, benefits are for fifty-two weeks' total, house-confining, and six weeks' non house-confining disability.

The policy may be written for $50 or $25. Weekly benefit and at annual, semi-annual, or monthly premiums.

The service, through the Blanksteen Agency, has been very satisfactory and proves that casualty insurance need not depend on technicalities evading responsibility.

The company is classed as an "A plus" company and we note that it has assets of $1.95 for every $1.00 of liabilities, olny equalled by a very few companies.

AUTOMOBILE INSURANCE

In automobile insurance we have progressed further in developing the *service* for members on claims against "the other party" in an accident. These cases, you know, are damages not covered by insurance but claimed against "the other party" and difficult to collect because they involve investigation, expense, and perhaps legal action, and victims neglect pushing their claims, which, however, are mostly collectable. During the eleven months of this report this service for claims totaling $2960 has been given to eighty-three members. It cost them nothing. The Agency's expense for attorneys' fees was $1080.95. In the preceding twelve months similar collections amounting to $3669 were recovered for twenty-four members. This equaled State Society dues @ $13 for 282 members or $1.30 for the whole membership. This service has so grown that we had to find means to legalize it and have arranged to offer our members at the special fee of one to three dollars (according to territory), without other obligations, membership in the Automobile Association of New Jersey. Other services are incidentally included.

Utmost choice of company is given every member, the responsibility of selection being his alone, the Society recommending none. We have sundered all connection with former companies and have not for months recommended them. And the Agency is entirely new. The Physicians' Underwriting Agency represents only "A plus" companies and they will give a bond to secure our members for every service rendered and funds handled.

Number of doctors insured, including increase of 51 and decrease of 53	1241
Total premiums written	$37,735.48
Premiums earned	18,735.48
Claims paid by Casualty Company	1,082.43
Claims reserved for payment by Casualty Company	1,109.00
Claims paid by Fire and Theft Company	150.65
Claims against others (collected or pending	2,960.92
Agency's expense for attorneys' fees for collections	1,080.95

We believe we have now perfected arrangements to:

1. Obviate the Society having any responsibility, moral or financial, for selection of company.

2. To render service of widest range including collection of claims against the "other party", and other advantages.

3. Afford perfect security for everything.

4. Grant group advantages to those who choose without putting any burden or obligation on other members or the Society.

We suggest recommendation by the Society.

This report concludes with this report made to the Board of Trustees.

Respectfully submitted,

To the Board of Trustees, Medical Society of New Jersey

Gentlemen:

The Committee on Insurance wishes to submit the following report, which is confined to two forms of insurance, (1) health and accident insurance and (2) automobile insurance.

Health and Accident Insurance.—The present group policy contains definite advantages which cannot be obtained by physicians as individuals. To enumerate:

1. A lower premium is possible due to the collective bargaining power of the group, since the

Company saves in expense, notably that of soliciting.

2. Arbitration of any disputed claim lies with the Committee on Insurance of the State Society, and the Company abides by the decision of the committee.

3. Cancellation of policy during the term, one year, cannot be made by the Company, whereas the customary individual policy can be cancelled by a company any time.

4. Our age limit in this policy is seventy, which is ten years beyond the customary age limit for health insurance in other policies.

5. A short form of application is permitted our members, whereas the form required by companies for individual policies is at least two and one-half times as long, and the extra questions, being more searching, as to the applicant's past medical history, result in more persons being denied insurance than under the short form.

For this policy your committee has selected the National Casualty Company of Detroit, whose rating is "A plus" (the very highest). We are well aware of the fact that during the past decade certain companies with a rating of "A plus" have failed and that should a similar financial crisis recur this might happen again. In 1933, due to the failure of the International Re-Insurance Corporation, five of our members suffered loss of their claims totaling $1200. Offsetting this, however, the prompt securing by the Blanksteen Agency of the present company to carry the insurance without new premiums for the year saved about $6000 in premiums to our members and thirteen of them collected claims the following year.

We would call attention to the fact the risks assumed by the insured are the same whether as individuals or as a group, but there are definite advantages in a group which cannot be obtained as individuals.

At a meeting of this committee on January 3rd, 1937, a motion made by Dr. Okin and seconded by Dr. Bloom was unanimously carried recommending to the Trustees of the State Society the continuance of the present set-up of Health and Accident Insurance as now in operation; and secondly, that the Trustees recommend that the county societies afford the Blanksteen Agency occasional opportunities to present to their members this form of insurance.

A specimen of this policy is enclosed.

Automobile Insurance.—In this insurance legal restrictions govern the premiums, which must be the same to individuals or to members of a group. But in *service* we can obtain advantages as a group which are utterly impossible to an individual. Notable among these is help in case of claim against the *other* party in an accident. We submit herewith for your consideration an offer to us from the Physicians' Underwriting Agency of services for collecting such claims and which also includes other advantages.

The committee recommends:

1. That the responsibility for selection of insurance company rests solely with the applicant for insurance himself.

2. That the selection and application for automobile insurance be made through a central office or bureau to be chosen by the Committee on Insurance.

3. That in consideration of the volume of business offered, the committee secure a list of specified services offered to the group by the central office as the basis of agreement.

4. That to fully protect every applicant for insurance in dealing with the central office, the latter shall, at its own expense, be bonded for $5000 by a responsible bonding corporation, although if payments for insurance premiums are made to the name of the underwriting company bonding the agent is superfluous.

We also suggest that the Trustees recommend to the county societies that they offer occasional opportunities for the central office to present to the members this form of insurance.

After considering propositions from others for service on the lines indicated, the committee recommends unanimously that an agreement be made with the Physicians' Underwriting Agency as per the attached form. This includes a certificate, and statement, of the Automobile Association of New Jersey, necessary to legalize the service.

Respectfully submitted,

LAWRENCE BLOOM
EDMUND H. HUFF
JOSEPH W. HURFF
IRVING OKIN
THOMAS J. SUMMEY
ALBERT J. WARD
E. ZEH HAWKES,
Second Vice-President
FRANK W. PINNEO,
Chairman

TO THE MEDICAL SOCIETY OF NEW JERSEY

In consideration of The Medical Society of New Jersey designating the Physicians Underwriting Agency of 22 Thirteenth Avenue, Newark, New Jersey, as the only authorized automobile insurance agency for the Society, the Physicians Underwriting Agency agrees to procure for the members of The Medical Society of New Jersey at a cost of from $1.00 to $3.00 (depending on territory), paid by each applicant, the following items which are not embraced in any casualty company's automobile policy, but are to be written in conjunction with any casualty company's policy so designated by each applicant of his own choice. The above charge is made to legalize services for the doctors regarding their claims for damages to their cars and also for the other services listed. All applies to the United States and Canada.

1. *Claim Collection Service.*—If anyone runs into and damages your car, you will be represented in collecting for the damages to your own car. This, you see, relieves the doctors of all annoyances in the case of an accident. This service for property damage shall be free and unlimited. In all cases, the insured shall give the utmost coöperation for the benefit of his own claim.

2. *$5000 Bail Bond Service.*—If you are involved in an accident or violate a motor vehicle law and are being held by the police for bail, arrangements will be made immediately for placing a bond for you at no expense to you.

3. *Tire Changing Service.*—If your tire goes flat, a service agency in the neighborhood will respond immediately.

4. *Towing Service.*—If your car is disabled or is involved in an accident and cannot proceed under its own power, it will be towed to your garage.

5. *Starting Cold or Frozen Motors.*—A sudden change in temperature during the Winter months and your car will not start due to a weak battery or cold motor. A telephone call to headquarters and within a short time you will be on your way.

6. *Starting Motors Stalled with Wet Ignition.*—This is not a seasonal service. It may be clear in the morning and there may be a downpour of rain in the afternoon. Servicemen respond immediately, regardless of the weather.

7. *Touring and Map Service.*—If you contemplate a trip, you will be supplied with all the necessary maps and complete itineraries.

8. *24-Hour Service.*—Headquarters are never closed. Think of the feeling of security you will have knowing that whatever trouble you may be in, service is available 24 hours a day, 365 days a year.

9. It is understood and agreed that in any case of difference between the Agency and the insured, the committee of the Society must be consulted.

It is further understood and agreed that the above services are guaranteed by the Automobile Association of New Jersey and that the Automobile Association of New Jersey will draft a special Certificate of Membership which will include these items and will be issued exclusively to the members of The Medical Society of New Jersey through the Physicians Underwriting Agency.

It is also understood and agreed that before an insurance policy is sold to a member of The Medical Society of New Jersey, the Physicians Underwriting Agency will advise the member as to the rating of the company given by the Alfred M. Best Corporation and of the importance of "A plus" rating (the very highest).

It is also understood and agreed that the Physicians Underwriting Agency will arrange for the placing of an indemnity bond in the amount of $5000 to guarantee the payment of all premiums for policies placed through the Agency.

It is also understood and agreed that The Medical Society of New Jersey will acquaint all its members with the fact that the Physicians Underwriting Agency is and will be the only authorized automobile insurance agency for the Society.

This agreement may be terminated by either party in sixty days' notice in writing, addressed to the post office address of the other party.

Very truly yours,

PHYSICIANS UNDERWRITING AGENCY, INC.

Know all men by these presents, That we, *Physicians Underwriting Agency, Inc.,* 22 Thirteenth Avenue, Newark, New Jersey, as Principal, and the *Indemnity Insurance Company of North America,* a Corporation of the State of Pennsylvania, authorized to do business in the State of New Jersey, as Surety, are held and firmly bound unto *The Medical Society of New Jersey,* hereinafter called the Obligee, in the sum of *five thousand* ($5000.00) dollars, for the payment whereof to the Obligee the Principal binds itself, its successors and assigns, and the Surety binds itself, its successors and assigns, jointly and severally, firmly by these presents.

Signed, sealed and *dated* this ..... day of February, 1937.

Whereas, The Medical Society of New Jersey has designated the *Physicians Underwriting Agency, Inc.,* as its sole authorized automobile insurance agency for the Society for the purpose of placing insurance policies and contracts on behalf and for the members of the Society.

And whereas, the *Physicians Underwriting Agency, Inc.,* guarantees that all payments made to it by members of *The Medical Society of New Jersey* in connection with the issuance of various contracts of insurance shall be remitted to the various companies issuing the policies and contracts of insurance.

Now, therefore, the condition of this obligation is such that if the said *Physicians Underwriting Agency, Inc.,* shall pay or cause to be paid to the various insurance companies all premiums collected from the members of *The Medical Society of New Jersey* for policies of insurance on their behalf, less any allowances or deductions made to the *Physicians Underwriting Agency, Inc.,* by said various insurance companies, then this obligation to be void, otherwise to remain in full force and effect.

Provided, however, that this bond is executed on the following conditions:

First: The Surety shall be advised by the Obligee, immediately upon their becoming informed of the occurrence of any default which may be made the basis of a claim hereunder, and affirmative proof of loss shall be filed within ninety (90) days thereafter.

Second: No suit to enforce the payment hereunder shall be commenced for a period of six (6) months after the filing of said affirmative proof of loss or after the expiration of fifteen (15) months from the filing of said proof of loss.

Third: This bond may be cancelled within sixty (60) days by written notice by the Obligee to the Surety stating the date the said cancellation shall become effective or by sixty (60) days' written notice and served upon the Obligee by the Surety

PHYSICIANS UNDERWRITING AGENCY, INC.

Dr. Pinneo added the following remarks:

There are two points we will make:

1. Free choice of your selection of company.
2. Free service in prosecuting your claims

against the other party in an accident, which service is not covered in any insurance policy.

This service in one year brought to our members collections which equalled the whole State Society dues of $13 each for 282 members, or $1.30 each for each of the whole membership. On automobile insurance we have now perfected arrangements which we think may be summarized in these four points:

1. Obviate the Society's having any responsibility, moral or financial, for the selection of the company.

2. To render service of widest range, including collection of claims against the other party, and other advantages.

3. Afford perfect security for everything, under a bonding company.

4. Grant group advantages to those who choose, without putting any burden or obligation on other members of the Society, or the Society itself.

These are the recommendations of that report.

Thank you! (Applause.)

PRESIDENT SNEDECOR: Thank you, Dr. Pinneo.

I believe the Board of Trustees has a reference to make to the House of Delegates in respect to the Committee on Insurance. Am I correct, Dr. Quigley?

DR. FREDERIC J. QUIGLEY: Yes, Mr. President. In short, the recommendation was that the Board of Trustees recommend that the Society disassociate itself from insurance on accident and health.

PRESIDENT SNEDECOR: No.

SECRETARY MORRISON: I think the Board of Trustees received the Report of the Committee on Insurance favorably, but did not advocate action by the Society,—just a receptive attitude.

PRESIDENT SNEDECOR: The Chair would like to explain his recollection of the action of the Board of Trustees. The Board of Trustees received Dr. Pinneo's report and studied it carefully, and recommended to the House of Delegates that the plan proposed by Dr. Pinneo's committee be approved if the Society decides that it wishes to continue to endorse automobile insurance; but the Board of Trustees did not advise the Society to continue automobile insurance. It did, however, endorse the Report of the Committee on Accident and Health Insurance.

DR. QUIGLEY: That is correct.

PRESIDENT SNEDECOR: With that reading of the report and the recommendation, I will refer it to Reference Committee "B".

Report, Sect. 75 D.

32. DELEGATES TO A. M. A.

PRESIDENT SNEDECOR: The report of the Delegates to the American Medical Association, Dr. Walt P. Conaway, Atlantic City.

Dr. Conaway said that the report of the Delegates to the last meeting of the American Medical Association, which was held on May 11-15, 1936, was printed in the Journal of June, 1936, page 367, as was announced in the Transactions of this House of Delegates of 1936, page 7.

33. POST-GRADUATE EDUCATION

(Very brief report, Jour., April, p. 240)

PRESIDENT SNEDECOR: Supplemental Report of the Committee on Post-Graduate Education, Dr. Satchwell.

Dr. Harry Satchwell presented his report, as follows:

REPORT OF COMMITTEE ON HOSPITALS AND MEDICAL EDUCATION

To the House of Delegates:

In 1935 by agreement with the Committee on Medical Practice it was decided that the part of the committee's activities relating to hospitals would be taken over by the Committee on Medical Practice inasmuch as that activity relating to hospitals was a matter of medical practice. This report, therefore, will be limited to education.

POST-GRADUATE EDUCATION

This year, as in past years, courses were given in the centers where the various county societies requested the same; namely,

Atlantic City for Atlantic and Cape May Counties
Camden for Camden and Gloucester Counties
Somerville for Somerset, Warren and Hunterdon Counties
Trenton for Mercer County.

A complete detailed report its appended.

CO-OPERATIVE COURSES

In coöperation with the Committee on Public Health and its Sub-Committee on Preventive Procedures in Child Health, the American Academy of Pediatrics, and the Bureau of Maternal and Child Health of the New Jersey State Board of Health, this committee carried out courses at Hackensack and Somerville as centers for all the adjoining counties, in preventive pediatrics.

By arrangement with the Committee on Preventive Procedures, this committee acted in an advisory capacity, arranged for the printing and mailing of bulletins, the securing of places for lectures and indicated the faculty. The Committee on Procedures secured the lecturers, furnished the curriculum and supervised the meetings. The use of teachers from the universities in New York and Philadelphia was again decided upon and the main-

tenance of that policy again proved its worth in the results obtained.

The lecturers were paid $30.00 for each lecture, this money being advanced from funds available through the State Department of Health, with Dr. Julius Levy as Director of the Bureau of Maternal and Child Health.

At Atlantic City and at Camden, on April 1st, 7th and 14th, two lectures were included in the regular post-graduate program as part of the Program in Preventive Pediatrics. On May 12th, 19th and 26th three lectures will be given at these centers to complete the five lecture courses at each place.

The detailed report of the pediatrics courses will be made separately.

This committee wants to express its appreciation to Dr. Julius Levy, Dr. Stanley Nichols and Dr. LeRoy A. Wilkes for their coöperation.

PLANS FOR 1937-1938

1. *Post-Graduate Courses.*—These courses will be given each year, as heretofore, at the centers used in past years. The policy of using teachers from the various universities will be adhered to.

In the Fall each county society committee will be contacted and courses will be made up of lectures chosen by them. These courses will be financed as usual by subscription.

2. *Prevention Pediatrics.*—A second series of advanced lectures will be given as the second year portion of a three-year program of Preventive Procedures in Child Health. These will again be given in coöperation with the committee of which Dr. Murray is Chairman. The financing will probably again be funds made available by Dr. Julius Levy, Director of the Bureau of Maternal and Child Health of the State Department of Health.

3. *Venereal Diseases.*—Courses of lectures on this subject from the public health standpoint will be given in coöperation with the Committee on Public Health, of which Dr. Stanley Nichols is Chairman.

4. *Fractures.*—At the suggestion of Dr. Snedecor and through contacts made for us by him, this committee will arrange courses on fractures to be given in coöperation with the Regional Committee on Fractures of the College of Surgeons, Dr. Clay Ray Murray, of New York, Chairman.

The tentative plan is as follows:

1. Lectures at a regular county society meeting as follows:
   a. "Treatment of Injuries" (emergencies). Lecture by some prominent New York or Philadelphia surgeon; 45 minutes.
   b. "Transportation of Injured." Movie—15 minutes.
   c. Demonstration of emergency treatments and "Fixed Traction Transportation" by a team of doctors; 15 minutes.
2. A course of five or six lectures similar in character to our present plan of lectures and given by the various county societies in coöperation with Rutgers.

   Suggested lectures:
   a. Diagnosis and treatment of injuries to shoulder.
   b. Injuries to spine. Low back pain and sciatica.
   c. Fractures and injuries to upper extremity.
   d. Diagnosis and treatment of conditions about the hip and knee.
   e. Fractures about the ankle and foot. Foot sprain and flat feet.
   f. Head injuries.
   g. Bone tumors.
   h. Other titles to be suggested.

5. *Coöperation with Other Committees of State Society if requested.*

The work of this committee began eight years ago under the chairmanship of Dr. Samuel Cosgrove. In this eight years most of the men of the State Society at some time have taken part in some one or more of the courses. A check two years ago showed that 50 per cent of the members of the State Society had subscribed to one course and that 80 per cent of these had taken more than one course.

This committee believes that it can say at this time that Post-Graduate Education should be made permanent. The policies of allowing each county society to choose the subjects of its lectures and the use of men of teaching grade except in exceptional instances where local men can be used as lecturers should be adhered to.

The program for 1937-1938 is very extensive. This year the Executive Officer and the office force of the Society have been of great help. If the extended program is to be carried out, the committee must depend even more upon the State Society's office force not only for clerical help but also for contact work with the various county societies. For this reason, the committee *recommends* that:

A *Department of Education* be established in the office of the State Society, the advisory group being the Committee on Hospitals and Education. This committee is a standing committee and must be retained. If this recommendation is approved by the Reference Committee and then accepted by the House of Delegates, it is further recommended that this matter be finally approved by the Trustees after the committee has had an opportunity to submit a detailed plan of procedure and personnel of such a department.

Another reason for this recommendation is that the Society be brought more into the lecture. At the present time the contacts with the various universities are personal ones. This has been necessary as a matter of course.

Respectfully submitted,

Harry Satchwell, *Chairman*
Stuart Hawkes
Arcangelo Liva
Dan Renner
David F. Bentley, Jr.

CHART A

POST-GRADUATE MEDICAL PROGRAM

Conducted by

THE MEDICAL SOCIETY OF NEW JERSEY

in Coöperation with

RUTGERS UNIVERSITY EXTENSION DIVISION

1936-1937

Registration in the Courses

Centers and Courses	No. of Doctors	No. of Internes	Total Registration
1. Atlantic City			
(Atlantic and Cape May Counties)			
1. Therapeutics and Preventive Medicine	74	10	84
2. Camden			
(Camden and Gloucester Counties)			
1. Medicine and Surgery	75	10	85
3. Somerville			
(Somerset County)			
1. Medicine	23	3	26
4. Trenton			
(Mercer County)			
1. Medicine and Surgery	78	18	96
2. Gastroenterology	78	18	96
	328	59	387

4 Centers; 5 Courses.

CHART B

Outline of Courses

	Opening Date	Closing Date	Time	Center	Course
1.	March 10	April 14	9:00 p. m.	Atlantic City	Therapeutics and Preventive Medicine
2.	March 11	April 15	8:30 p. m.	Somerville	Medicine
3.	March 16	April 20	4:00 p. m.	Trenton	Medicine and Surgery
4.	March 17	April 21	4:00 p. m.	Camden	Medicine and Surgery
5.	March 19	April 23	4:00 p. m.	Trenton	Gastroenterology

CHART C

1936-1937

FACULTY

Number of doctors who lectured this year, from:

New York	7
Philadelphia	15
Brooklyn	1
Total number of lecturers	23

Irving Applebaum, M.D., New York University Medical College, New York.

H. L. Bockus, M.D., Professor of Gastroenterology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

Russell Cecil, M.D., Professor of Clinical Medicine, Cornell University Medical College, New York.

Burrill B. Crohn, M.D., Attending Physician, Mt. Sinai Hospital, New York.

Harry M. Eberhard, M.D., Professor of Gastroenterology, Hahnemann Medical College, Philadelphia.

John C. Gittings, M.D., Professor of Pediatrics, University of Pennsylvania Medical School, Philadelphia.

Harry Gold, M.D., Associate Professor of Pharmacology, Cornell University Medical College, New York.

William Goldring, M.D., Assistant Professor of Clinical Medicine, New York University Medical College, New York.

Richard A. Kern, M.D., Assistant Professor of Medicine, University of Pennsylvania Medical School, Philadelphia.

John A. Kolmer, M.D., Professor of Medicine, Temple University School of Medicine, Philadelphia.
Frank W. Konzelmann, M.D., Professor of Clinical Pathology, Temple University School of Medicine, Philadelphia.
Karl Kornblum, M.D., Assistant Professor of Radiology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.
Harry Koster, M.D., Chief Surgeon, Crown Heights Hospital, Brooklyn, N. Y.
Raphael Korzrok, M.D., Associate in Obstretrics and Gynecology, College of Physicians and Surgeons, Columbia University, New York.
Collier F. Martin, M.D., Professor of Proctology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.
George P. Muller, M.D., Professor of Surgery, Jefferson Medical College, Philadelphia.
Damon B. Pfeiffer, M.D., Associate Professor of Surgery, Graduate School of Medicine, University of Pennsylvania, Philadelphia.
I. S. Ravdin, M.D., Harrison Professor of Surgery, University of Pennsylvania Medical School, Philadelphia.
Martin E. Rehfuss, M.D., Professor of Clinical Medicine, Jefferson Medical College, Philadelphia.
Hobart Reimann, M.D., Professor of Medicine, Jefferson Medical College, Philadelphia.
Bela Schick, M.D., Director of Pediatrics, Mt. Sinai Hospital, New York.
William D. Stroud, M.D., Professor of Cardiology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.
Ralph M. Tyson, M.D., Professor of Pediatrics, Temple University School of Medicine, Philadelphia.

CHART D

April 23, 1937.

POST-GRADUATE MEDICAL PROGRAM

1936-1937

FINANCIAL REPORT

Cash received	$ 250.00	
Estimated cash collectable	1,000.00	
Estimated total income		$1,250.00
Direct Field Expenses		
30 lectures @ $25.00	$ 750.00	
Travel expenses of lecturers	282.00	
Printing	117.20	
Travel expenses of University Extension Staff	234.50	
University telephone and postage	159.00	
One-sixth time of stenographer	180.00	
Total expense		1,722.70
Deficit		$ 472.70

PRESIDENT SNEDECOR: The report of the Committee on Graduate Education will be referred to Reference Committee "D".

Action, Sect. 77.

34. COMMITTEE ON PREVENTIVE PROCEDURES AND CHILD HEALTH

DR. SATCHWELL: It was my intention to have the Committee on Preventive Pediatrics make its own report, and I see Dr. Murray approaching the platform.

Dr. Harold Murray presented the Report of the Committee on Preventive Procedures and Child Health, as follows:

REPORT OF COMMITTEE ON PREVENTIVE PROCEDURES AND CHILD HEALTH

To the House of Delegates:

When it was found that funds were available for education of the physicians in prenatal work and preventive pediatrics, it was decided to give courses throughout the State in preventive procedures in child health. Accordingly, by coöperation with the Committee on Hospitals and Education, a plan of procedure was determined upon and courses arranged.

The following courses were given:

Somerville, five lectures
Hackensack, five lectures
Camden, two lectures
Atlantic City, two lectures

At Atlantic City and Camden, two lectures were included in the regular post-graduate course. The five-lecture course in pediatrics will be completed in these two centers in May, making a total of four courses of five lectures each given throughout the State.

By agreement with the Committee on Education, that committee acted in an advisory capacity, selecting the centers and the lecturers. This committee secured the lecturers requested, set up the curriculum, and supervised the lectures.

The Executive Offices of the State Society took care of the printing and mailing. Through these four centers the medical men of the entire State were given an opportunity to attend.

Lecturers were paid $30.00 per lecture out of funds made available by Dr. Julius Levy, Director of the Bureau of Maternal and Child Health of the State Department of Health.

The attendance at the four centers was as follows:

Centers and Courses	No. of Doctors	No. of Internes and Nurses	Total Registration
Atlantic City	74	10	84
Camden	75	10	85
Hackensack	200	20	220
Somerville	60	50	110
	409	90	499

On May 12, 19, 26 the continuation of the pediatric lectures in Atlantic City and Camden will be carried out. The enrollment cannot be estimated.

The policy adopted by the Committee on Education of using as lecturers teachers from the various universities was carried out. The entire pro-

gram in preventive procedures in child health will take three years to cover.

The second year will cover the care of the pre-school child.

The third year will cover the child of school age.

HAROLD A. MURRAY, Newark,
Chairman
IRVING OKIN, Passaic
WALTER STEWART, Atlantic City
BENJAMIN M. JOSEPH, Jersey City
WILLIAM GORDEN, Perth Amboy
ERNEST G. HUMMEL, Camden

PRESIDENT SNEDECOR: These excellent reports on Graduate Education, and Preventive Procedures in Child Health are referred to Reference Committee "D", Dr. Myatt, Chairman, for study and report back tomorrow.

Action, Sect. 77.

35. COMMITTEE ON PROGRAM AND ARRANGEMENTS

(Report, Jour., April, p. 241)

We will go on to the Committee on Program and Arrangements. Is Dr. Kaighn here? There was no reply.

Action, Sect. 76 B.

36. COMMITTEE ON SCIENTIFIC WORK

(Report, Jour., April, p. 241)

PRESIDENT SNEDECOR: Report of Committee on Scientific Work, Dr. Lange.

DR. LANGE: Our report has already been published.

PRESIDENT SNEDECOR: Have you no supplemental report?

DR. LANGE: No.

PRESIDENT SNEDECOR: The Report of the Committee on Program and Arrangements is referred to Reference Committee "C". The Report of the Committee on Scientific Work goes to Reference Committee "C".

Action, Sect. 76 C.

37. COMMITTEE ON SCIENTIFIC EXHIBITS

(Report, Jour., April, p. 242)

Report of the Committee on Scientific Exhibits, Dr. Yaguda.

DR. ASHER YAGUDA: The report has been published and will probably be referred to the Reference Committee, but we have a supplementary report on the award of prizes for this year's exhibits, and we will announce the awards now.

For original research work, and an exhibit based on it:

First prize, Drs. W. G. Exton and Antin R. Rose, Clinical Laboratory Methods, Electroscopometry, Booth 32.

Second prize, Drs. William Bierman and E. A. Horowitz, Treatment of Gonococcus Infection in Female, Booth 15.

Third prize, to Dr. Joseph B. Wolffe and Dr. Victor A. Digilio, for work in The Use of Enzyme-free Pancreatic Tissue Extract in the Treatment of Angina Pectoris and Arteriosclerotic Cardiovascular Disease; Booth 27.

For excellence in composition of material:

First prize to Dr. J. W. Cutler, for his exhibit on Pleural Adhesions Complicating Pneumothorax Therapy; Booth 18.

Second prize to Dr. I. Seth Hirsch, for his exhibit on the Roentgenkymographic Examination of the Heart; Booth 17.

Third prize to Dr. Charles Robert Rein, for his excellent presentation of the Kline Tests for the Detection of Syphilis; Booth 21. (Applause.)

PRESIDENT SNEDECOR: Thank you, Dr. Yaguda. We are all very well aware of the work of the Committee on Scientific Exhibits, as we come into this room. I refer the report to Reference Committee "C".

Report, Sect. 76 D.

38. WELFARE COMMITTEE

(Report, April Jour., p. 245)

Report of the Welfare Committee, Dr. Hilton S. Read.

DR. HILTON S. READ: No additional report other than that in the Journal.

PRESIDENT SNEDECOR: I will refer the report of the Welfare Committee to Reference Committee "C".

Report, Sect. 76 E.

39. SUB-COMMITTEE ON PUBLIC HEALTH

(Report, April Jour., p. 246)

Report of the Sub-Committee on Public Health, Dr. Stanley Nichols.

Dr. Nichols read the supplemental report of the Sub-Committee on Public Health, as follows:

Since the regular report was written there has been published by the American Foundation a book of studies called "American Medicine". This book is the most important volume affecting the private practice of medicine since the publication some years ago of the book called "Costs of Medical Care for the American Public".

This volume called "American Medicine" is the re-

sult of a study of the ideas of several thousand representative physicians, influential in State medical societies and keenly concerned with the problems of adequate medical care confronting the American people.

We strongly recommend a careful study of this book by all of our members, and most particularly its general conclusions, which are roughly two in number—first, that private practice should continue as before, with one exception. Second—this one exception is that the medical profession should join hands with the public authorities for the providing of adequate medical care to the indigent and low-wage group by a process of evolution and not by revolution.

As many of you know, health insurance is now being re-studied by Professor Hamilton of the Social Security Board in Washington. Health insurance is positively the worst threat to prviate practice, as it inevitably will cause a deterioration of the quality of medical care, should it be put into effect by law. It is our sincere hope that the expressed opinion of our nation-wide medical leaders, as detailed in this volume of "American Medicine", will successfully combat, in our national capital, this threat of health insurance, and give our organized medical profession—national, State and county —the opportunity to develop this needed medical service for our indigent and low-wage group in conjunction with our public authorities, by a process of careful evolution.

This is precisely the path The Medical Society of New Jersey has been following for several years, and I trust that our national legislators will see the wisdom of continuing this wise development.

Even if health insurance should become a Federal law, it would necessarily, like the Social Security law, not become effective in any State until the State Legislature developed its coöperative law. Therefore, our opportunity during this coming year is to carry on our present progressive plans to improve the public health so well and so thoroughly, that our State legislators will feel that our present developments are superior to any plan of revolutionary health regimentation imported from Europe.

Team Work Among Health Professionals in New Jersey.—A sound plan on behalf of better public health necessarily involves a gradual development of good health team-work among all the full-time health professionals, namely doctors, dentists, nurses, hospital workers, pharmacists, health officers and medical social workers, and also involves keeping public groups and the public generally well informed of the growth of such plans.

The Medical Society of New Jersey during the past year has made notable progress in the development of such relationships. Our State leaders have met repeatedly with the New Jersey Hospital Association with the resulting better mutual understanding; they have discussed common problems with the New Jersey State Dental Society in our allied medical conferences; our Nursing Committee has conferred frequently with the three groups of nurses in the State; our Joint Committee on Professional Relations is developing the better use of drugs with the New Jersey Pharmaceutical Association; our many State and county health committees work constantly with the State and local health departments in many fields; and last, but not least, Dr. Kler's Committee on Public Relations has done yeoman service already in making clear and well-known to many public groups the viewpoint of the medical profession in this State, and has brought before us a splendid plan for the coming year, by which the ideas, the plans and activities of our medical profession in New Jersey will be kept constantly in the public eye all over the State during this vital year which lies immediately before us.

Such health team-work cannot fail to bring dividends to both our individual members and the public which we serve, but such leadership and teamwork can fail if not strongly supported by two factors through the year to come. These two factors are: First, steady improvement of the personnel and administrative equipment in every county medical society office, as well as in the State headquarters. Second, the providing of *sufficient* funds for efficient operation by the administrative personnel and the many committees of physician members, who are working hard for the benefit of their brother practitioners.

There is to be expended this coming year over one-half a million dollars of State funds for medical services; and local health departments and agencies will spend over a million more in the various public health fields outlined in the Social Securities Act. If we are to control the delivery of this needed medical service by our physician members and thus endeavor to see that only qualified medical personnel, approved by our county medical societies, shall be used in the expenditure of this vast amount of money, we must improve our operating machinery very rapidly during this coming year. We have succeeded in guiding the appointments of over 100 physicians during the past year, recommended by the county societies. If we do not continue to increase the efficiency of our county and State societies in the delivery of high quality medical service, this golden opportunity will largely slip from our grasp into the eagerly outstretched, waiting hands of political or social welfare groups.

By thus increasing the ability of our County and State Society to aid their component membership in this assumption of responsibility for both individual and public health, our individual doctors will be assisted by post-graduate and clinical training to render to their individual patients high quality maternal care, better health supervision of the infant, the pre-school and school-age child; routine health supervision of the adult group; special care of problems such as cancer, tuberculosis and venereal disease; the adjustment of mental atttiudes to the problems of environment that perplex all age groups; in short, to supervise the health routinely of all ages of his patients in addition to curing them when ill.

For the purpose of assisting our physicians, our committee expects to have 5 x 8 record cards available for the use of all our members during the com-

ing year, covering each of the age periods of life; namely, Dr. Bingham's pre-natal and obstetric record card, an infant record card, our present preschool record card, now being used entirely in the present New Jersey State Parent-Teacher Summer Round-up; Dr. Ireland's family doctor record card for the school-age child, now in process of preparation, and Dr. Glazebrook's adult health record card. These, we feel, will all be very useful to our member physicians.

We have over three thousand member physicians. Each physician has between two hundred and a thousand patients on his list. Even allowing for duplications, let us say an average of five hundred. If each physician develops his own practice in preventive medicine by making his office a health center, it will gradually solve the problems of one to two million people, or nearly *half* of our State population. The problems of the othre half will doubtless have to be solved by the county medical societies, which, in their assumption of responsibility for the health of all of the people in each county, must necessarily, in conjunction with the rest of the public and private health agencies, study the problems involved, and furnish the needed qualified medical personnel with a special concentration on behalf of the health problems of the indigent and low-wage group.

In this development, it will be necessary for every member of each county society to do his share by serving on some committee or in some capacity aiding organized medicine to do this job better than ever before. For an individual doctor to offer real preventive medicine to all of his patients,—for a *county medical society* to assume full responsibility for the health of all citizens in its county,—for a state medical society to assume leadership and responsibility in all of the health fields needed for better health for the citizens of the State; these are each gigantic tasks and will continue to challenge the best efforts of all of us, individually and collectively, for years to come.

The most crucial year for American medicine and the preservation of private practice for our physician members lies immediately before us. I will prophesy that when this House of Delegates meets in 1938, the die will be cast and the direction which private practice for physicians will take will be definitely visible to all of us. Let us all, at the conclusion of this convention of the House of Delegates, go home to our county societies and do our best to urge every one of our 3000 members to carry high the torch of full medical responsibility during the coming twelve months, both for individual and the community health, and to buckle on the armor of high courage, unceasing labor and solid-welded, loyal team-work, and fight valiantly for the permanent objective of The Medical Society of New Jersey, *"Better medical service to the people of New Jersey, through the preservation of private practice"*.

Respectfully submitted,

Public Health Committee,
Stanley Nichols, *Chairman.*

President Snedecor: I will refer Dr. Nichols' report to Reference Committee "E".

Action, Sect. 78 A.

40. Committee on Medical Practice

(Jour., April, p. 253)

We will now have the supplemental report of the Committee on Medical Practice, Dr. Lewis.

Dr. Thomas K. Lewis: Mr. President and Members of the House: In view of the fact that the final report of the Sub-Committee on Medical Practice is largely a resumé of the work done by the Advisory Committees, I believe it will be unnecessary to read it at this time; however, one brief paragraph I would like to present on Workmen's Compensation.

Dr. Lewis read the first paragraph on the second page of the supplemental report. The entire supplemental report is as follows:

FINAL REPORT OF THE SUB-COMMITTEE ON MEDICAL PRACTICE

After discussion and careful analysis of the activities and reports of its several advisory committees, the mother committee wishes to stress briefly the highlights of the year's work and ask the approval of the House of Delegates for continuation of the many projects which have been undertaken.

Hospital Relationships.—Intimate relationship and close coöperation with the New Jersey Hospital Association during the past year has accomplished much in furthering a better understanding with the various lay elements in our hospitals. It is believed that a continuation of this policy will go far toward the correction of many controversial hospital problems peacefully

The Hospital Survey, while far from complete, is sufficiently comprehensive to warrant certain definite recommendations.

Care of the destitute in all hospitals (except State-operated institutions) is inadequately supported financially by the various communities. Combined State and voluntary contributions, on the average, pay about one-third of the cost of this service. When our data is complete, we would recommend that the Sub-Committee on Public Relations enter the field and propagandize the public on a State-wide scale for more adequate financial support of the care of the indigents in our privato hospitals.

Uniformity of system of control of surgery and other special procedures within hospitals is recommended.

Hospitalization insurance, particularly as it is operated under the Hospital Service Plan of Newark and the Mutual Hospital Service Plan of Elizabeth, is approved as a definite forward step in the solution of medical economic problems. The committee is aware of the fact that the services of physicians in certain specialties are being sold by

the hospitals and expresses its disapproval of this state of affairs. However, because of the wide variation of contracts under which these specialists have connected themselves with hospitals, it is impossible, at present, to correct this abuse. Special committees from the ranks of the pathologists and the roentgenologists have been requested to work on this problem with the object of providing a uniformity of hospital contract or relationship. Both the above-mentioned insurance groups are anxious to coöperate in the solution of this problem.

Pharmaceutical Problems.—The work of Dr. Ulmer's committee is commended and its continuation is advocated. The support of the entire profession is requested in this effort toward team-work with the pharmacists for more ethical prescription writing.

Medical Care of the Indigent.—Progress in this field, of necessity, is dependent upon appropriation of funds by the State Legislature. Dr. Schlichter's committee is keeping in mind the one essential principle: State control with the medical profession as partner in supervision.

Nursing and Nursing Education.—This committee has done some real pioneering work. We would particularly recommend further study of the problem of the nursing attendant. The creation of this type of subsidiary worker would not only solve the practical nurse problem but would fill a long-felt need for pateints in the low-wage group.

Workmen's Compensation.—The report of this committee is heartily approved and although there are some controversial aspects we recommend definite action by the House of Delegates in order that the committee may be justified in the preparation of a new bill or amendments to the existing act. It is suggested that this report be given meticulous consideration by the reference committee and that all interested parties attend the meeting of this particular reference committee in order that Dr. Fort's committee may know definitely the will of the Society with regard to the operation of workmen's compensation.

Contract Practice.—This committe has been breaking virgin soil, for, while the A. M. A. has laid down certain general rules for governing contract practice, yet the local application of these regulations is in many cases quite difficult. We consider the work of this committee of vital importance in that contract practice is implicated in many of the complex problems confronting the practice of medicine. Standardization of the principles of ethical contract practice and a method of controling the situation within the county societies are the objectives. We would plead for the coöperation of every physician in New Jersey with Dr. Sharp's committee in the development of its program.

T. K. Lewis.

President Snedecor: Thank you, Dr. Lewis. Your report goes to Reference Committee "F", also the report might be referred to the Committee on Workmen's Compensation, if you prefer.

Report, Sect. 80a.

41. Sub-Committee on Legislation

(Report, Jour., April, p. 253)

Sub-Committee on Legislation, Dr. Pollak. He is unable to be present today because of a death in his family.

Report of Reference Committee, Sect. 76 F.

Dr. Wilkes: There is the report on the pneumonia serum legislation now pending.

President Snedecor: Dr. Gray will cover that.

Sect. 58.

42. Sub-Committee on Public Relations

(Jour., April, p. 254)

Report of Sub-Committee on Public Relations, Dr. Kler. If there is no supplemental report, I will refer Dr. Kler's report on Public Relations to Reference Committee "B".

Report of Reference Committee, Sect. 75 F.
See also paragraph 59.

43. Advisory Committee on Child Health

(Jour., April, p. 257)

Report of the Advisory Committee on Child Health, Dr. Stewart. That report is referred to Reference Committee "E".

Report of Reference Committee, Sect. 78 C.

44. Maternal Welfare

(Jour., April, p. 257)

Report of the Advisory Committee on Maternal Welfare, Dr. Bingham. That report is also referred to Reference Committee "E".

Report of Reference Committee, Sect. 78 E.

45. Crippled Children

(Jour., April, p. 258)

Report of Advisory Committee on Crippled Children, Dr. Weigel. That is referred also to Reference Committee "E".

Report of Reference Committee, Sect. 78 D.

46. Treasurer

(Jour., April, p. 259)

Report of the Advisory Committee on Tuberculosis, Dr. Pollak. Referred to Reference Committee "E".

Report of Reference Committee, Sect. 78 G.

47. Cancer Control

(Jour., April, p. 260)

Report of the Advisory Committee on Can-

cer Control, Dr. Orton. I have a letter from Dr. Orton saying that because of his son's illness, he will be unable to be present. There is no supplemental report for the Cancer Control Committee. I will refer his report to Committee "E".

Report of Reference Committee, Sect. 78 B.

48. Venereal Disease Control

(Jour., April, p. 264)

Report of Committee on Venereal Disease Control, Dr. Shivers.

Dr. C. H. deT. Shivers: There is no additional report. The report as given appears in the Journal.

President Snedecor: I will refer that to Reference Committee "E".

Report of Reference Committee, Sect. 78 H.

49. Mental Hygiene

(Jour., April, p. 266)

Report of Advisory Committee on Mental Hygiene, Dr. Plant. That report is also referred to Reference Committee "E".

Report of Reference Committee, Sect. 78 F.

50. Contract Practice

(Jour., April, p. 272)

Report of the Advisory Committee on Contract Practice, Dr. Sharp.

Dr. R. L. Sharp: No additional report.

President Snedecor: I will refer your report to Reference Committee "F".

Report of Reference Committee, Sect. 80 B.

51. Hospital Relationships

(Jour., April, p. 272)

Report of the Advisory Committee on Hospital Relationships, Dr. Lewis.

Dr. Lewis: No additional report.

President Snedecor: I will refer that report to Reference Committee "F".

Report of Reference Committee, Sect. 80 C.

52. The Indigent

(Jour., April, p. 275)

Report of the Advisory Committee on Medical Care of the Indigent, Dr. Schlichter. If there is no additional report, that will be referred to Reference Committee "F".

Report of Reference Committee, Sect. 80 E.

53. Workmen's Compensation

(Jour., April, p. 275)

Report of the Advisory Committee on Workmen's Compensation, Dr. Fort.

Dr. J. Irving Fort: No additional report.

President Snedecor: That is referred to Reference Committee "F", calling particular attention to the problem of taking a position in Workmen's Compensation Practice.

Report of Reference Committee, Sect. 80 F.

54. Pharmaceutical Problems

(Jour., April, p. 271)

Report of the Advisory Committee on Pharmaceutical Problems, Dr. Chester I. Ulmer. This is also referred to Committee "F".

Report of Reference Committee, Sect. 80 G.

55. Woman's Auxiliary

(Jour., April, p. 279)

Report of the Advisory Committee to the Woman's Auxiliary, Dr. Van Ness.

Dr. H. Roy Van Ness: No additional report.

President Snedecor: That is referred to Reference Committee "B".

Report, Sect. 75 E.

56. State Board of Medical Examiners

(Jour., April, p. 279)

Report of the State Board of Medical Examiners, Dr. McGuire. There is no additional report, I believe. That is referred to Reference Committee "D".

57. Nursing and Nursing Education

(Jour., April, p. 273)

Did I skip any committees. Committee on Nursing and Nursing Education. There is no additional report, and that is referred to Reference Committee "F".

Report, Sect. 80 D.

58. Anti-Pneumonococcic Serum

(Sect. 41 and Jour., May, p. 352)

President Snedecor: There is a report of a special committee I should like to receive at this time. It was recently appointed at the request of the State Department on Pneumonia Serum. Dr. Gray will give a report.

Dr. Gray: This committee met on April 20, at the State Department of Health. It was recommended that the Medical Society should support the bill for the appropriation of funds for the purchase and distribution of anti-pneumonococcic serum for indigent patients in the State. Certain changes were recommended in the wording of the bill which were approved by Mr. Taggart, who proposed the bill. It was suggested that a plan similar to those in New York State and in Massachusetts should be worked out in this State for the purchase and distribution of anti-pneumonococcic serum to indigent patients.

The subject of immune serum for the treatment of scarlet fever and measles also was dis-

cussed, and it was recommended that the pediatric group and superintendents of contagious disease hospitals should be consulted regarding the need of such serum. (Applause.)

PRESIDENT SNEDECOR: This is another instance of increasing the responsibility of the State organization. A sudden problem comes up in pneumonia and we have to take part in it. I will refer your report, Dr. Gray, to Reference Committee "E", which is considering most of the other public health reports. The Chairman of Reference Committee "E" is Dr. Areson.

Report, Sect. 78 I.

59. COMMITTEE ON PUBLIC RELATIONS (Continuing Section 42)

(Report, April Journal, p. 254)

At this time I should like to recognize Dr. Kler, who just came in, with a supplemental report of the Public Relations Committee.

DR. JOSEPH H. KLER: Two things have come up to which the Public Relations Committee wishes to refer.

Dr. Kler read the supplementary report, as follows:

SUPPLEMENTARY REPORT OF THE SUB-COMMITTEE ON PUBLIC RELATIONS

Since preparing the annual report of the Sub-Committee on Public Relations, several matters require a supplementary report.

1. The attached letter from Robert A. Watson, District Manager, New Jersey State House, Authority, request our support of the passage of the Wagner-Steagall Bill. This bill provides funds for housing projects. If this bill becomes law, it will be possible to eliminate, at least to a certain measure, the unsanitary conditions found in the "slums" of cities. The bill has no provisions for medical care in any way. Because of its character, this committee recommends this bill for your approval and authorizing your committee to so inform our Federal legislators.

2. *Whereas,* At the last meeting of the Welfare Committee, the Committee on Public Relations brought before them the subject of eugenic sterilization, and

Whereas, The Welfare Committee moved that this subject be brought before the House of Delegates at their Annual Meeting in April 1937;

Therefore, Be It Resolved, That the House of Delegates now in session go on record as favoring the appointment of a Special Committee of the Welfare Committee to study the subject of eugenic sterilization and act as a bureau of information for scientific facts bearing on this subject.

Respectfully submitted,

JOSEPH H. KLER, M.D., *Chairman.*

DR. KLER: We are not recommending that the Society either favor or oppose it, merely to study it.

PRESIDENT SNEDECOR: That report has already been referred to Committee "B".

Report, Sect. 75 F.

PRESIDENT SNEDECOR: Are there any other reports? Is there any other Unfinished Business?

60. INAUGURAL ADDRESS OF PRESIDENT HERRMAN

(Jour., May, p. 338)

PRESIDENT SNEDECOR: I should like at this time to present to the House of Delegates the man who will take office at the close of this session as the President of The Medical Society of New Jersey, and I should like to ask two members of the Monmouth County Medical Society, Dr. Featherston and Dr. Fisher, to escort Dr. William G. Herrman, the next President of The Medical Society of New Jersey, to the platform.

Dr. Featherston and Dr. Fisher escorted the newly elected President, Dr. William G. Herrman, to the platform while the assembly arose and applauded.

PRESIDENT-ELECT HERRMAN: Mr. President and Mr. Secretary, and Fellow Members of The Medical Society of New Jersey: I want to concur in some remarks that were made this morning in regard to Dr. Morrison, our Retiring Secretary. There is a provision in Congress that where a man has once been a member of the House, he thereafter has the privilege of the floor. Dr. Morrison, we have seen you grace this platform for so many years that I want to say that I hope we will see you continue as long as God may give you life to attend these meetings, and next year I hope that you will consider it your right at any time to sit on this platform.

SECRETARY MORRISON: Thank you. (Applause.)

President-Elect Herrman presented the following prepared remarks:

Dr. Snedecor during the past year started a happy innovation which I intend to continue. He has considered the President-Elect, the Vice-Presidents, the Chairman of the Board of Trustees and the Chairman of the Welfare Committee as his Cabinet. He has called upon them for aid and assistance in carrying on the work of his office. I am going to call upon them very shortly after this Annual Meeting to formulate with me a program for the coming year based upon the desires of this Society as indicated by the action of the House of Delegates at this meeting.

At this time, let me merely say I feel the past administration has been a most successful one, especially in improving the organization of the Society, in amplifying the work of the county societies and in integrating their work with that of the parent Society.

Much time and thought has been given in cooperating with Government agencies, in the medical aspects of the Social Security Act, to wit: maternal health, child health, venereal disease, crippled children and old-age pensioners.

For years we have talked about correlation of the medical and the administrative side of hospital activities. In the past year for the first time has any attempt been made to survey the hospitals of the State through a questionnaire. We hope to continue this investigation and have ready for you next June some recommendations.

The proposals of the Workmen's Compensation Act Committee, I believe, merit our support. An effort will be made during the coming year to have conferences with the Department of Labor, employers and insurance carriers, so as to modify some of the more objectionable features of the present Workmen's Compensation Act.

The survey of the Cancer Control Committee has shown how sadly lacking are the present facilities in this State for coördinative care of the cancer case, be it indigent or private. Pneumonia or typhoid fever can be taken care of by one physician, but many cases of cancer, to be adequately treated, must be handled by a group. It is up to us to develop a plan by which such group treatment can be made available in the various sections of our State. This program will be one of those which I hope to emphasize during the coming year.

Our Public Health Committee has attempted, during the last few years, to recapture for the private physician many phases of preventive medicine which we ourselves have allowed to stray in the hands of the laity, to our loss, and, I believe, with less benefit to the public than if they were carried on by medical men themselves.

"Big Business" has demonstrated for years that any article could be sold to the public, provided it was sufficiently advertised. The ban against advertising by the individual physician, incorporated in our code of ethics, has been interpreted by a great many physicians as prohibiting advertising by medical organizations. But in this day and generation, if we wish to influence the public mind to see things as we see them, we must advertise our wares. We have been fortunate in the past year in forming a Public Relations Committee, which gives great promise of extending proper medical information to all parts of the State. We hope to extend and amplify the work of this committee.

The Committee on Nursing Education has devoted considerable time and thought to preparing a two-fold plan for providing better nursing facilities for both hospitals and those who are ill at home and do not or cannot afford the help of a registered nurse. We believe that this active committee can be continued and encouraged.

The State Medical Society as at present organized, representing more than a majority of the practicing physicians in this State, may logically expect to speak officially for all of the physicians of the State in its contact with other organized groups of citizens or with State or Governmental agencies. But this fact should not deter us from making every effort to amplify our members, so that we may have among our members every ethical physician in New Jersey.

In due time a detailed program of the coming year will be published in the Journal. Until then, may I state that by and large, we feel that the policies of the past recent administrations should be continued—that we approve, by and large, the work of the various committees during the past year, and hope that this work will be continued along much the same lines.

Gentlemen, I thank you for your greeting.

PRESIDENT SNEDECOR: The retiring President, gentlemen, would like to express to Dr. Herrman his sincere and loyal support during this coming year, and to add that he has received the very best of support that Dr. Herrman has been able to give him.

Speaking for the Medical Society, I am sure we all are with Dr. Herrman in wishing him a most successful year. (See Reference Committee, Sect. 74 C.)

61. EXPENSE OF HUDSON COUNTY APPEAL TO A. M. A.

(See paragraph 18)

PRESIDENT SNEDECOR: With all old business cleared up, we will go on to New Business.

DR. THOMAS MCG. BRENNOCK: I wish to present this resolution. It is the consensus of the Delegates of Hudson County that this resolution be introduced in the House of Delegates, Mr. President:

"Whereas, The Judicial Council of the American Medical Association has found that the election of the Hudson County Medical Society held October, 1935, was held according to the Constitution and By-Laws of the county society and of the State Society, and that the findings of the Judicial Council were contrary to law and not within the scope of their duties; and, further that the Trustees were not within their powers in recommending a denial of a hearing before the House of Delegates; and

"Whereas, the House concurred in these actions; and

"Whereas, In order to defend its rights and to clear the membership of aspersions cast upon them by the action of the Judicial Council, the Board of Trustees and the House of Delegates, the County Medical Society was forced to expend certain moneys; therefore be it

"Resolved, That the State Medical Society reimburse the Hudson County Medical Society in the sum of Fifteen Hundred and Fifty Dollars, and that the Treasurer of The Medical Society of New Jer-

sey be and is hereby authorized to draw a check on the Contingent Fund for the above-mentioned sum to the order of the Hudson County Medical Society.

"Maurice Shapiro,

(Signed) "Joseph F. Londrigan."

President Snedecor: Do you wish to make a motion that this resolution be adopted by the House of Delegates?

Dr. Brennock: I move the adoption of this resolution.

Dr. Evans: I second the motion.

President Snedecor: The resolution as presented by the gentleman from Hudson is now open for debate. What is your pleasure?

Dr. Frederic J. Quigley: I should just like to read Article X, Section 1, of the Constitution, which states:

"Current expenses of this Society shall be met by an annual per capita assessment upon the members of each component society; by donation; by sale of the society publications; and from miscellaneous revenue. During the Annual Meeting, funds may be appropriated by the House of Delegates for the expenses of the Annual Meeting, for publications, for expenses of officers and committees, but for no other purpose, unless authorized by a two-thirds vote of the members of the House of Delegates than present, and approved by the Board of Trustees."

President Snedecor: Thank you, sir. Is that all right?

Several Members: Perfectly!

President Snedecor: Are you ready for the question? The question before the House is the adoption of the resolution presented by the Hudson County Medical Society. Do you wish me to read it?

Many Members: No!

Dr. Elias J. Marsh: I am not just sure what section Dr. Quigley read, but, for the information of the gentlemen, because they may want to amend this resolution, I call attention to this provision of the By-Laws, Chapter 9, Section 4:

"All motions and resolutions appropriating money for special purposes shall fix a definite sum, and shall state the budget account against which the expenditure is to be charged. Such resolutions must be passed by the House of Delegates and approved by the Board of Trustees."

President Snedecor: Your motion, Dr. Brennock, is defective in that it does not state from which budget account the money is to come.

Dr. Brennock: We don't care what fund —from the Contingent Fund we feel it should be taken.

Dr. Shapiro: I second that amendment.

President Snedecor: The resolution as amended states that this is to be taken from the contingent fund. Is there objection to the amendment? Hearing none, I declare it part of the original resolution. Are you ready for the question? All those in favor of the resolution presented by Hudson County Medical Society, please say "aye"; opposed, "no". It will be necessary to have a standing vote.

Member: It seems to me on questions of this nature we should vote by ballot.

Many cries of "No, no."

A rising vote was taken, resulting in 28 for and 60 against.

President Snedecor: The motion is lost.

Dr. Shapiro: I saw red badges standing.

Secretary Morrison: I counted only blue badges.

President Snedecor: We will proceed with the next order of business. Are there any further motions?

Dr. Hilton S. Read: I have a couple of motions to offer.

62. Hygeia, and the A. M. A.

Dr. Read: I move that our delegates to the American Medical Association be instructed to introduce a resolution into the House of Delegates calling for an investigation into the conduct of the magazine Hygeia,—particularly as to articles that prescribe for the laity, and into the methods employed by the business manager in circularizing the laity with literature designed to at least imply that Hygeia magazine will take the place of a medical adviser.

I move the adoption of that resolution.

Dr. D. Leo Haggerty: I second the motion. (Action, Jour. A. M. A., June 26, p. 2208.)

The motion was carried.

Dr. Read: I move that this body officially request the Woman's Auxiliary to The Medical Society of New Jersey to cease its activity in behalf of the circulation of the magazine Hygeia. The motion was seconded by Dr. Haggerty, was put to a vote, and was carried. (See page 103.)

Secretary Morrison: I would suggest that a copy of this last resolution be sent to Dr. Fishbein.

President Snedecor: We will take that under advisement.

Next, Dr. Alexander!

63. CONSTITUTION AND BY-LAWS

(Continuing paragraph 14)

DR. SAMUEL ALEXANDER: Committee on Constitution and By-Laws—the Reference Committee met this morning, and as a result of this meeting, we have the following recommendations to make:

At this time we would recommend that the State Constitution be changed as follows:

Jour., April, p. 231.

Article IV—*Composition of the Society;* Section 3—*Election of Delegates.* (d) Vacancies. Amend by inserting after the first comma on the fourth line the following words, "or fails to attend two consecutive meetings (annual or special) except in case of illness".

PRESIDENT SNEDECOR: This seems to me to be awfully technical, and I wonder if you can't take it up in sections for a vote and not go through the full report first.

DR. ALEXANDER: May I say, President Snedecor, that the Constitution and By-Laws provide that any amendment to the Constitution be presented at this meeting and then published in the Journal, sent to the component societies, and voted upon at the next Annual Meeting; so for the purpose of conforming with these provisions there is no further action necessary at this time.

PRESIDENT SNEDECOR: Will you explain the purpose of these as you go along?

DR. ALEXANDER: The purpose is that a delegate who doesn't attend two consecutive meetings except because of illness, should not be a delegate to this convention.

The other change we should like to suggest at this time:

Article IV, Section 5—Honorary Members. Amend by adding the following sentence to end of Section:

"This does not affect the rights of an Officer, Fellow, or Active Member of The Medical Society of New Jersey."

The reason for that is that at this time there seems to be some confusion as to whether an Honorary Member is entitled to the rights of an Active Member of the Society; and in order to clarify the point, we are recommending that amendment.

64. BY-LAWS AMENDMENTS

(Continuing Sect. 14)

DR. ALEXANDER: Now, the By-Laws:

Chapter I, Section 2, Official Lists fo Members, (a)—Amend by deleting the present wording and substituting:

March fifteenth in each year is the final date for closing the Official List of members. Five days before this date the Treasurer of each component society shall forward to the Treasurer of this Society a complete list in duplicate of all paid-up members in good standing, with their correct addresses, at the same time remitting the assessment covering such membership. The Trustees shall arrange for the compiling and publication of the Official List from the lists so received by the Treasurer.

The purpose of that is to make it more expedient for the officers of this State Society to get a correct list from the component societies. Up to the present time, February 1 is the date set for the compilation of this list, and we feel March 15 would be more satisfactory.

Under the By-Laws this is to be at this meeting submitted again tomorrow and a vote called for tomorrow.

(b) Amend by striking out "On the first day of February" and substituting "On the fifteenth day of March".

The same purpose as the previous amendment.

(d) Amend by deleting the semicolon on the sixth line, and replacing a period. Also delete the remainder of this paragraph.

SECRETARY MORRISON: So it will then read what?

DR. ALEXANDER: At the present time Section (d) says:

"The Official List as published each year shall be prima facie evidence of the right of members to register at the Annual Meeting; and unless otherwise ordered by the House of Delegates, shall form the basis of representation of each component society" * * *

We stop there under the amendment, and delete the following part:

* * * "except that after the Official List is printed, any component society which finds that it is entitled to additional delegates and alternates may elect these at its April or May meeting."

Chapter VII, Section 6—Duties of Councilors.—Amend by deleting the whole section.

The reason is that the duties imposed in Section 6 are not necessary in view of the fact that the officers of the Society are going to take over some of the work done by the Councilors heretofore.

Chapter VI, Section 3. Amend by deleting entire present wording and substituting:

"The Secretary of the Society shall have the custody of the Constitution and By-Laws of the Society, and of the records of the Society and the

House of Delegates, under the direction of the Board of Trustees. He shall attend all meetings of the Society and of the House of Delegates, and shall keep a record of their proceedings. He shall give notice of all general and special meetings of the House of Delegates or of the Society, to the members of the said House or Society. He shall notify Honorary Members of their election.

"He shall require and receive from the Secretaries of the County Societies a list of their representatives in the House of Delegates and the Nominating Committee, and shall publish such lists at such times and in such manner as the House of Delegates may direct.

"He shall have the sole custody of the Official Seal of the Society and shall affix the same to such correspondence or instruments as the By-Laws may require or the Trustees or the President may direct.

"He shall conduct such formal official correspondence in the corporate name of the Society as the Trustees or the President may direct. The Board of Trustees shall make suitable provision for the detail and clerical work of the Secretary.

"He shall submit annually to the House of Delegates a report of the work of his office, and shall furnish to the Board of Trustees or to the President, upon request, such information as may be necessary for the Society's business, and shall perform such other functions as are specified in these By-Laws.

"He shall be entitled to necessary expenses in attending meetings or otherwise incurred in the transaction of the Society's business, as authorized by the Trustees."

The reason for that resolution is that, under the new set-up, the Executive Officer will do many of the things that the previous Secretary has done.

Amend Chapter I, Section 2 (a), by deleting the present wording and substituting:

"March 15 in each year is the final date for closing the Official List of members. Five days before this date the Treasurer of each component society shall forward to the Treasurer of this Society a complete list in duplicate of all paid-up members in good standing, with their correct addresses, at the same time remitting the assessment covering such membership. The Trustees shall arrange for the compiling and publication of the Official List from the lists so received by the Treasurer."

That is in conformity with changing the date from February 1 to March 15.

Dr. Alexander read changes to Chapter IX, Section 2 (a). For context, see page 48 of these proceedings.

That is in conformity with the general set-up, March 15 and not February 1.

Dr. Alexander read changes to Chapter I, Section 4. For context, see page 49 of these proceedings.

The purpose of this is one of expediency to make it easier for the delegates to get their cards and badges at the Annual Meetings.

Chapter X, Section 3. See page 49 of these proceedings for context.

The reason for that is very obvious.

"Now the standing committees are being changed."

Chapter VIII, Section 2. See page 50 of these proceedings for context.

Chapter VIII, Section 6. See page 51 of these proceedings for context.

Chapter VIII, Section 7. See page 52 of these proceedings for context.

Chapter VIII, Section 8. See page 52 of these proceedings for context.

Chapter VIII, Section 9. See page 52 of these proceedings for context.

Chapter VIII, Section 10. See page 52 of these proceedings for context.

Chapter VIII, Section 10, page 30. See page 53 of these proceedings for context, ending with word 'President", fifth line from bottom of page 53.

Chapter VIII, Section 11. See last four lines on page 53 for context.

Section 10—Committee on Post-Graduate Education.

"The Committee on Post-Graduate Education shall consist of five members. It shall be the duty of this committee to provide a continuous program of post-graduate education for the members within the resources of the Society. It shall advise upon, correlate and promote all of the post-graduate activities of the special committees in coöperation with them. It may provide regular courses, special courses, or special meetings, and may work in coöperation with educational institutions."

Chapter VIII, Section 12. For context see page 54 of these proceedings, and then continue with the rest of pages 54 and 55.

Tomorrow I will present them again for final vote.

At this time I should like to offer the following resolution, under New Business.

President Snedecor: Well, Dr. Alexander, the proposed amendments to the By-Laws which you have just read require no action by this body at this time. They will come up tomorrow afternoon for discussion and action.

65. Defining Active, and Associate Membership

Dr. Alexander: That is right. I should like to offer the following resolution:

"*Associate Members* of component societies shall be physicians who may be elected to active mem-

bership after a period of probation. All others now called Associate Members shall be termed *Courtesy Members.*"

There seems to be a great deal of confusion in the various societies and county organizations as to what an Associate Member is, and what a Junior Member is; and to clarify the situation, I offer that resolution.

PRESIDENT SNEDECOR: That is not an amendment.

DR. ALEXANDER: Just a resolution.

PRESIDENT SNEDECOR: Would you mind referring that to the Committee on Resolutions to report back tomorrow, so it will have proper consideration? Is there any objection? If not, I will refer that resolution to the Committee on Resolutions. (Action, Sect. 83.)

DR. E. R. MULFORD: Dr. Snedecor, I should like to ask that the Delegates to the A. M. A. please have those resolutions as soon as possible so we can get them drafted, because three copies have to be presented and we should like to have them as soon as possible.

PRESIDENT SNEDECOR: Upon whose shoulders will that fall?

SECRETARY MORRISON: The Executive Office.

PRESIDENT SNEDECOR: Anything else, Dr. Alexander?

DR. ALEXANDER: At the meeting of the Reference Committee this morning, Dr. Shapiro, of the Hudson County delegation, presented certain amendments to the Constitution and By-Laws; and so, for the sake of the record I wish to make that report at this time.

66. TRUSTEES, NUMBER AND ELECTION

DR. MAURICE SHAPIRO: Mr. President and Gentlemen: We had a pleasant session with Dr. Alexander. I want to say I never met a Chairman of a committee who gave us such a courteous hearing, and we did a lot of work this morning without fuss or bother. We took each other's opinions and discussed them and decided what was best for the Society.

We have one matter that the committee did not want to commit itself on, and in all fairness to them, I want it known that they don't oppose it. They didn't approve it, but they asked us to present it on the floor and, therefore, we are going to present this proposition to you now.

"Whereas, The Medical Society as now constituted is a becameral body consisting of the House of Delegates, which functions at meetings of the Society; and of the Board of Trustees, which acts as an executive body and manages the Society in the intervals between meetings; and

"Whereas, The proposal of the Board of Trustees——"

Now, this is water that has gone over the dam, because the Trustees have recalled the amendment that they wanted, if you recall, eight to be elected by—well, I will read that in here:

"Whereas, A proposal of the Board of Trustees in their report, and as presented by the Committee on Constitution and By-Laws, to amend Article VI of the Constitution so that eight members of the Board of Trustees would be members ex-officio, and seven members to be elected by the House of Delegates, is in our discretion undemocratic and tends towards oligarchy; therefore, it is the opinion of the delegates from Hudson County, in order to prevent such concentration of power in the hands of a few, and in accordance with the statements of the Board of Trustees in this annual report, that the duties and affairs of the Board of Trustees are becoming unusually heavy, we recommend the adoption of the attached proposed amendment to be substituted for that of the Committee on Constitution and By-Laws."

Of course, there is no substitution now.

Now our reason, briefly, for bringing that up is that we have heard only this morning from a number of members that there is a movement to divide the state into two counties—the opposite of our friend who called it the Hudson State Medical Society, Dr. Newcomb. I am calling the State the County. We feel in Hudson that we are not represented, and certain other counties feel that way. Therefore, we propose this amendment:

"Article 6, Board of Trustees of the Constitution:

"Strike out the entire Article and substitute as follows:

"The Board of Trustees shall be the Executive Board and shall be composed of twenty-eight (28) members, as follows: The President, President-Elect, two Vice-Presidents, Secretary and Treasurer, all ex-officio by virtue of their offices, and twenty-one (21) members, one from each component County Society, who shall be elected by the said component County Society, as follows:

"One week after the adoption of this amendment, the President of each component County Society shall call a special meeting at which a member to the Board of Trustees shall be elected. At a reasonable time after these elections, the President of the State Society shall call a meeting of all the Trustees for the purpose of organizing the Board of Trustees. At this time the twenty-one (21) elected Trustees shall draw by lot who shall serve for one year, who for two years, and who for three years; i. e., seven (7) for one year, seven (7) for two years, and seven (7) for three years. At this

meeting they shall also, from the complete membership of the Board of Trustees, elect a Chairman and Secretary.

"As the terms of each elected Trustee expires, each component society so affected shall at the annual election preceding the expiration of the term of said Trustee elect a Trustee for the period of three years.

"MAURICE SHAPIRO

(Signed) "JOSEPH F. LONDRIGAN."

That is submitted by the Hudson County Delegation and signed by myself and Dr. Londrigan. (Applause.)

PRESIDENT SNEDECOR: That is an amendment to the Constitution. That requires no action till next year.

DR. SHAPIRO: That is submitted for first reading.

PRESIDENT SNEDECOR: It will be published as part of the minutes of this meeting.

67. AMEND BY-LAWS ON FINANCE COMMITTEE

DR. SHAPIRO: We have another amendment, to the Committee on Finance, Chapter VIII, Section 5, of the By-Laws:

Amend by striking out the following:

"The Committee on Finance shall consist of three members elected by and from the Board of Trustees and three members elected by the House of Delegates, and their terms of office shall be for six years, provided that the term of one Trustee shall expire every second year, and the term of one Delegate member on each alternate year."

And substitute therefor the following:

"The Committee on Finance shall consist of one member elected by and from the Board of Trustees and one member from each Judicial District by and from the House of Delegates. The terms of the elected members shall be for a period of three years. The terms of two shall expire each year, except in the case where one shall expire in one year.

"MAURICE SHAPIRO

(signed) "JOSEPH F. LONDRIGAN."

PRESIDENT SNEDECOR: That is an amendment to the By-Laws. It will be read again tomorrow and come up for action, and in the meantime, is there any objection to referring that to the Reference Committee on Constitution and By-Laws?

DR. SHAPIRO: Oh, the Constitution and By-Laws Committee has that already, and we handed that in for reading today.

68. DATE OF OFFICIAL LIST

DR. ELIAS J. MARSH: May I suggest to Dr. Alexander and the Committee on By-Laws that they might like to withdraw for the present their suggested amendments to the section on Official List and changing the date from the first of February, for the assessment, not from objection to the change itself, but for the reason that the Trustees and some of the Reference Committees and otherwise among the Finance Body have before them a question of reorganization of the entire financial system with regard to bringing the fiscal year and the assessment year into harmony. If we adopt this change now, it is all right in itself, but we might have to change it again, and I think possibly they might like to withdraw it from that angle.

PRESIDENT SNEDECOR: They might like to consider your suggestion carefully, but if anything is to be done about it this year, it had better stay in the record. They can recommend its withdrawal tomorrow.

DR. MARSH: I wanted to make the point that we might make a change and have to reorganize it next year, and that would be a mistake.

PRESIDENT SNEDECOR: Will you give your opinion to the Committee on Constitution and By-Laws?

DR. MARSH: Yes.

69. COUNCILOR OF SECOND DISTRICT,— LEGALITY OF ELECTION

Action, Sect. 85.

DR. G. S. KERDASHA (Hudson County): Mr. Chairman and Members of the House of Delegates: I want to take this opportunity to inform the members of the House of Delegates that the position of Councilor in the Second District is now vacant. Originally Dr. Sweeney was elected a member of the Judicial Council while a Delegate of this District. His term expired in 1934. He was illegally elected a Councilor in 1935. Now, in support of that contention, I want to read to you Article VII of the Constitution:

"The House of Delegates shall organize five (5) Councilor Districts within the State. This Society shall elect one (1) Councilor from among the Delegates of each such district; and these elected Councilors, collectively, shall constitute the Judicial Council."

Now, it is perfectly obvious from the By-Laws just what it means and, therefore, I say to the House of Delegates that the posiiton of Councilor at the present time in the Second

District is vacant, and we are obliged to elect a Councilor for the Second District.

Regardless of what the opinion of many members of the House of Delegates may be, I feel—it was unfortunate in the past that we have deviated and wandered away from the Constitution, to our sad regret; and I hope that in the future we do not wander any more, and that we are not obliged to bring reflection upon ourselves by going to the American Medical Association to have them tell us how to read and interpret the Constitution.

We have it and I think an intelligent and honorable body of men such as we have here should be able to read the Constitution and live up to it. If we have a Constitution, let's live up to it; and if we don't care to, let's scrap it. There are one or two things to do, scrap it, or live up to it; and if we don't, can't, do that today, and if we have to, year in and year out, appeal to the American Medical Association to tell us how to interpret our Constitution—so, I appeal to this body here to observe the Constitution and accord to Hudson County what is due to it.

We feel that our position of Councilor in the Second District is now vacant and we ask the House of Delegates at this time to fill this vacancy.

President Snedecor: Dr. Kerdasha, the Chair will entertain a motion, if you wish to make it.

Dr. Kerdasha: I make a motion that the House of Delegates proceed to elect a Councilor for the Second District.

President Snedecor: I can't entertain that motion, Dr. Kerdasha. I am sorry I cannot, but I would entertain a motion before this House that the position of Councilor in the Second District be declared vacant because the present incumbent was elected illegally. I think that is in order. Would you like to make such a motion?

Dr. Kerdasha: I make such a motion.

Dr. Shapiro: I second the motion.

President Snedecor: Now, gentlemen, you have before the House a motion made by the gentleman from Hudson to the effect that the Judicial Councilor's position in the Second District is declared vacant because of the illegal election of the present incumbent two years ago. Before opening this up for discussion, I should like to read to you the Constitution and By-Laws, in which it says, Chapter XI—Resignation or Removal of Officers:

"Any officer of this Society may resign his office, or he may be removed therefrom by a two-thirds vote of the House of Delegates, when guilty of neglect of duty, improper conduct, or upon violation of the Constitution and By-Laws. In either or all cases the Society shall fill the vacancy so made as provided for in Article IX of the Constitution, and in Chapters V and VI of the By-Laws."

Therefore, favorable action upon this motion requires a two-thirds vote of this House of Delegates.

I suggest that this can be handled in two ways. It can be handled by continuing discussion now from the floor, with a presentation of this matter, and come to a question; or it can be handled by appointing a committee of this House to take up this matter and refer it back to this body with a recommendation for action later.

Dr. Shapiro: May we amend the original motion then that a committee be appointed by the Chair to investigate this matter and refer it back to the House tomorrow afternoon?

President Snedecor: Is that agreeable? I would prefer that because it seems to me due time can be given and careful consideration.

Gentlemen, you have heard the motion made by the gentleman from Hudson County, seconded and amended, to the effect that the position of Councilor from the Second Judicial District be declared vacant, and that a committee of five be appointed by the Chair to look into and consider all aspects of this question and report back to the House of Delegates tomorrow afternoon.

Dr. Shapiro: I should like to ask a point of information. Will that permit us to go into the committee and present our case?

President Snedecor: I don't see how the committee could properly function without hearing your side of the case.

Dr. Shapiro: The Judicial Council has done it.

Dr. Marsh: I am asking for a point of information. Is this a question of removal of an officer from office, or a question of declaring an election void from the beginning? There is a legal distinction in the two points.

President Snedecor: Will you make it clear what the legal distinction is for an officer who has served two years——

Dr. Marsh: But if the election was void at the beginning, it is voiding an election as being illegal from the start; if it is an illegal election and your are removing him from office on account of misconduct, that is different.

President Snedecor: This is for removal because of illegal election.

Dr. Abram Weiss (Hudson County): To me this really doesn't come under the articles read by the President for the removal of an officer. There is no officer to remove. It is merely a question of the Society's recognizing

the fact that through error or some other cause, a person was sitting in the seat of an officer who really wasn't an officer. The officer has never existed as such, and it only is required that the Society recognize that fact and it does not come under the question of removing an officer.

President Snedecor: Dr. Weiss, the Chair would rule that since this Society has accepted the Councilor from the Second Judicial District for two years, it must consider removing him from office at this time, because of illegal election.

Dr. Thomas K. Lewis: I don't believe that is it. I think a motion should be clearly stated to indicate that the office is vacated. It makes a difference in procedure. Removing an officer implies misconduct. I think the proper procedure is to declare the office vacant.

President Snedecor: Dr. Alexander, may I ask your opinion?

Dr. Alexander: I think Dr. Lewis's contention is correct.

President Snedecor: All right, the Chair will then change the motion. Do you want to restate it, Dr. Kerdasha?

Dr. Kerdasha: I make a motion that the position of Councilor in the Second District is now declared vacant; and appeal to the House of Delegates to fill that vacancy.

President Snedecor: And that a committee be appointed, and so forth.

Secretary Morrison: And I would suggest in the appointment of these five delegates that they all be chosen from the Second Judicial District.

President Snedecor: The Chair will take under advisement the appointment of the committee.

Dr. Lancelot Ely: This matter came before the Nominating Committee last year, and when we discussed Dr. Sweeney, the question arose:—if a man is serving as a Judicial Councilor for a period of term of office, and he at the next year was not appointed as a Delegate, or his term of delegation ran out, would he still continue as a Judicial Councilor? or would he, by being withdrawn from the House of Delegates, likewise lose his position as Councilor?

We threshed the thing out in the Nominating Committee and we felt——

Dr. Londrigan: Oh, no!

Dr. Ely: You were there, Dr. Londrigan.

Dr. Londrigan: Yes, but you didn't "thresh it out".

Dr. Ely: We proceeded, and the question still arose, and it is true that the Nominating Committee didn't know what to do, and so it went on.

President Snedecor: It is quite apparent that it is necessary to ferret out the facts in the case. It is a difficult question.

Dr. Londrigan: I don't like to do this with Dr. Ely, but it was not threshed out in the Nominating Committee last year. I believe I was there from the beginning. Appoint your committee and let's get through with it.

President Snedecor: Are you ready for the question?

Dr. Alexander: Would you have the motion read, if you please?

The last motion was read. (P. 53.)

Dr. Kerdasha: I make a motion that the position of Councilor in the Second District is now declared vacant and appeal to the House of Delegates to fill that vacancy.

President Snedecor: And that a committee be appointed. (P. 129, stenotype.)

President Snedecor: Do you understand the motion now?

Dr. Norman W. Burritt (Union County): I am not sure that I do understand this. The committee, then, does not advise the House of Delegates as to whether we shuold declare that vacant or not, but by this vote we do declare the office vacant.

Cries of "No, no, no."

President Snedecor: By this vote we appoint a committee. I thought you understood that. She (the stenotypist) did not read all of the motion. That included the appointment of a committee to study all aspects of this question and report back a recommendation to the House of Delegates tomorrow afternoon.

Dr. Shapiro's amendment to Dr. Kerdasha's motion (p. 126) appears on page 127. This motion to amend received no second, but apparently received consent, and is included in the President's restatement of the motion, on page 127. Dr. Kerdasha restated part of the motion on page 129 to conform to Dr. Lewis's suggestion, and President Snedecor implied that Dr. Shapiro's amendment was included, in his statement immediately thereafter.

Dr. Quigley: May I say that I think Dr. Burritt's point is well taken. I think we are agreed to have the matter referred to a committee for it, after investigation, to recommend whether in its opinion the office should be declared vacant.

President Snedecor: That is correct.

Dr. Quigley: I should like, then, to amend the motion or ask the original introducer to reread the resolution.

Dr. Kerdasha: The contention of the members of the Hudson County delegation is

that it is vacant, and we amended that by asking that a committee be appointed to declare it vacant.

DR. QUIGLEY: I move to amend the motion, that the present eligibility of the incumbent of the Second Judicial District is in question and I move that a committee be appointed to consider the matter and report back its recommendations tomorrow.

PRESIDENT SNEDECOR: That is an amendment to Dr. Kerdasha's motion. Do you want to accept that?

DR. KERDASHA: That is O K.

There were several seconds offered.

PRESIDENT SNEDECOR: No objection. Now is this motion with its amendment understood by the House?

All in favor of the motion signify by saying "aye"; opposed "no".

The motion was carried with one dissenting vote.

PRESIDENT SNEDECOR: It is so ordered and this question is referred to a special committee which the Chair will appoint within a short time. (See Sect. 85.)

DR. SHAPIRO: There has been a question of the eligibility of certain members to hold office in this Society and in the American Medical Association, due to the fact that they have been elected members of the honorary body, or been elected Honorary Members. We, therefore, from Hudson County, would like to be put on record that we did not accept the interpretation of the Chair and of the body of this House, and that we reserve the right to appeal from the decision of the Chair and from the House, to the Judicial Council of the American Medical Association.

PRESIDENT SNEDECOR: The Chair will ask that your statement be recorded in the minutes.

Is there further business?

DR. ALFRED STAHL: In reference to this office, it would seem to me that if the records of the Society could be produced as to that year, they would solve the whole problem.

PRESIDENT SNEDECOR: Present that to the committee. The essential point to be determined is obvious. Was the gentleman from Hudson elected two years ago, a Delegate?

DR. STAHL: I offer that as a suggestion. Will the Secretary assist the committee by producing the records?

SECRETARY MORRISON: The only original records I have here are the transactions of 1935, which show that he was elected Councilor from that district; and we have a sworn affidavit from the Secretary of Hudson County Medical Society to the fact that at that time he was not a Delegate.

President Snedecor returned the affidavit to Dr. Brennock at this time.

DR. STAHL: I mean the cards.

SECRETARY MORRISON: We do not keep the cards.

70. CITIZENSHIP REQUIRED FROM APPLICANTS FOR LICENSE TO PRACTICE

DR. HERSCHEL S. MURPHY (Union County): I should like to bring up a matter I brought up last year. Some of you probably will remember it. I will read the resolution:

> *"Resolved,* That the Delegates of the State Medical Society of New Jersey recommend that the Medical Practice Act be amended to read: 'That applicants for license to practice medicine in the State of New Jersey must be citizens of the United States.'" (Transactions, 1936, Sect. 43, p. 20.)

I introduced that last year and it was referred to the Welfare Committee. We discussed it during the year, and from what I gather and from the Chairman of the Welfare Committee's ideas, it is the sentiment of the members of the Welfare Committee that this is an advisable thing to do, provided we can get it past the Legislature. There is no question but that it will be difficult to get it past the Legislature, but, nevertheless, it can be tried. It doesn't do any harm to try.

I should like to read a few brief phrases from the records of the Official Transactions from last year, just to refresh your memory. We brought out the fact last year that there were already six or seven States that require citizenship in order to practice in the State. Now the question of constitutionality is being brought up, the fact that you cannot keep a man from practicing medicine if he has filed his intentions of being a citizen. I have it on pretty good authority that that does not hold, that there is nothing in the Constitution that says a man who filed his application for citizenship is entitled to all the rights and privileges of a citizen, but it says that all citizens are entitled to equal rights and privileges; therefore, from what I have been able to find out, this was not unconstitutional.

This was discussed last year by Dr. Satchwell, myself, Dr. Kelly, Dr. Morrison, and Dr. Marr, and, as I said a moment ago, I will bring out two or three other things about it. I brought out last year the fact that in South America, in Brazil and Argentina and other countries, a man must live in the country ten years before he can take the examination to practice, and in Canada a man must live there

five years before he can apply for the right to practice medicine; and somebody brought out about the fellows from McGill, and we answered that when a man puts in four years in McGill and a year of interneship, he naturally fulfills the five-year requirement.

I don't know whether you noticed in the New York Times a few days ago an account of Mayor LaGuardia and Representative O'Connor, from the State of New York, talking to a meeting in New York City and advised the dropping of all the immigration barriers, and once more allowing America to become the "home of the brave and the free", and letting all the healthy people over there who can't make a living over there, come here.

We brought out last year the fact that under the quota system if they don't open up the barriers, a man who has a profession or a trade, who is well trained and well educated, and perhaps has a small amount of money, is given preference; and physicians do come under this exemption, as you all know, because they are well trained.

Last year this was recommended, as I say, to the Welfare Committee. This year I should like to see the House of Delegates, if the President thinks it wise, or if he wishes to refer it to a Reference Committee, that is agreeable, but I should like to see some action on it. It might be referred to the Medical Practice, or the Committee on Legislation, and have it reported back again tomorrow.

Another thing that happened last year,—and I am reading from these notes, so my remarks will be disconnected—Dr. Morrison brought out the fact that in England, Russia, Germany, and France, anyone who applies has to have full citizenship in order to practice in those countries.

Now, this doesn't interfere with anyone who goes from the United States to England or to France and studies medicine, who is an American citizen before he goes. Our thought is entirely in regard to men who want to come to the United States because they think it is easier to practice in the United States than in the country from which they would come. We can't go to their countries and I don't see anything discriminatory if we request, through our State Legislature, that they should not be allowed to come to our country to practice medicine without becoming full citizens.

After they become full citizens of the United States, that is an entirely different matter. I don't think it makes any difference whether New York does it or Connecticut does it. As long as other States have done it, and some seven or eight have done it, and have passed this law, I see no reason why it wouldn't be a good thing for New Jersey, especially since we are so near New York, where the majority of the men are coming in from foreign countries. They are admitted into New York City and New York is only a step across our line; therefore, I present this resolution to the President to deal with as he sees fit.

I hope it is referred to a Reference Committee, and tomorrow we may be able to voice our approval of this if we see fit to do so and, in turn, we can perhaps contact the legislators. Maybe we won't get it through this year. Maybe it will take ten years but, gentlemen, I think it is worth trying.

Thank you! (Applause.)

President Snedecor: Dr. Murphy, I would refer your resolution, if there is no objection, to Reference Committee "D", which is considering the Report of the Board of Medical Examiners. Is there any objection in the House?

Dr. Van Ness: Is there any objection to moving its adoption?

Member: Reference Committee!

Dr. Murphy: I merely suggested that it be referred to the Reference Committee. I did that in case the men were not in agreement with it or didn't understand it. If they want to vote on it now, I shall be glad to withdraw my suggestion that it be referred to the Reference Committee, and if they want to vote on it now, that is perfectly agreeable.

Cries of "No, do it now. Now, now, vote on it now."

President Snedecor: The sentiment seems to be, since there is an objection to referring it to a Reference Committee, that a vote be taken on this resolution at this time.

I will read the resolution so it will be before the House:

> *"Resolved,* That the Delegates of the State Medical Society of New Jersey recommend that the Medical Practice Act be amended to read: 'That applicants for license to practice medicine in the State of New Jersey must be citizens of the United States.'"

It is now open for discussion.

Dr. H. Roy Van Ness (Essex County): I move its adoption.

The motion was seconded by Dr. John H. Irwin.

The question was called for.

Dr. Maurice Shapiro: There is debate on this.

Dr. Londrigan: The question is whether the Medical Examiners would like some in-

formation on this. Is Dr. James McGuire in the House? May we hear from him?

Dr. James J. McGuire: Under the present Medical Act, any applicant to secure a license to practice in the State must file with the Board the declaration of intention. He must complete his citizenship within six years. If that is not done, his license is automatically revoked.

In the State of New York they are allowed ten years. There are several States that do require full citizenship. There never has been an expression of opinion for the Board and I am not speaking for the Board but for myself. I feel that a man before he is licensed should be a citizen. (Applause.)

I know some men have McGuire down here as a pessimist in regard to medical legislation. I am somewhat pessimistic with reference to many bills introduced in the Legislature affecting the medical profession. I know at the time we even tried to get this declaration of intention, we had a fight for about five years before we eventually convinced the legislators it was to the advantage of the public as well as the profession that a man become a citizen.

I hope that through persuasive powers or some other influence we will convince the Legislature that it is to the advantage of the public. I still have my doubts, but, as Dr. Murphy says, it won't do any harm to try. So many men feel we have so many foreigners coming into this country, that I have made a report to the Society with reference to the number of foreigners who have come into the country; and if you look at that report, you will be somewhat surprised to find that there are not so many foreign-educated, foreign-born that we are admitting to licensure. In the last year we licensed, I think the figure showed—I forget now, but I think there were only some seven or eight foreign-born, foreign-educated men that we admited to licensure last year.

We admitted to licensure some eighteen men who had gone to foreign universities and were foreign-educated, but they were American-born. There are not as many foreigners as formerly. It has been gradually decreasing every year. There was a time when we did have a great number of men coming in from other countries who were foreign-born and foreign-educated, but as I said a little while ago, I am heartily in sympathy with this resolution, and I am sure the Board would be, to have men attain full citizenship before they apply for license.

President Snedecor: Do we need much further debate?

The question was called for.

Dr. Shapiro: Against the motion, please. I think we have a right to be heard. I am not talking for Hudson County; I am talking as an individual, and I am going to say something that may seem rather radical to you people. I am talking as a Jew. Now, remember that.

You gentlemen just now are in a flush of excitement that we have foreigners coming into this country taking our bread and butter away from us. Let me ask you in this body how many of your fathers came over on the "Mayflower"? You are medical men today by the grace of God that your fathers came to this country, and you were permitted to go to the public schools, permitted to go to college, and to study medicine.

I felt the same way as Dr. Murphy does, about 1919 and 1920 when we had an influx of German and Austrian doctors, because they couldn't make a living. One man in particular was brought over by General Allen because he thought he was a wonderful doctor; and I resented it. I thought they were coming over here taking my bread and butter away. That was a different story; but when you attempt to stop a Jew, or a Christian, who is being persecuted in Germany or in any other country, from coming over here and trying to make a livelihood, you are forgetting the principles of America. You want every man to have a chance. These men are persecuted. Some of them are the most brilliant men in the world. You have heard of Yadzung, the great dermatologist. Any book on the subject you take up will refer to him. He and his son had to get out of Germany, and they died of broken hearts.

I could cite innumerable instances not only of Jews but of Gentiles, who were in the same boat and are in the same boat. You are going to close the door of this great country. You are going to say, "Get out. We don't want you."

I ask you gentlemen, before you vote on this, consider the moral side of it. It may hurt us a few pennies; as Dr. McGuire said, only seven or eight were admitted. I don't think the influx will be so tremendous. The influx is growing lower and lower. Give these men a chance. Let them get in and try to make a living. I know of a couple of them in Brooklyn. One man in particular is with my brother-in-law in his office, getting free rent, free light. He is a noted urologist of Berlin. He was wealthy, and he can't even get started. In the six months he has been with my brother-in-law he has seen only one case.

They are having a hard time, so don't make it any worse for them, please.

Dr. Murphy: I should like to say, in answer to Dr. Shapiro, that we all feel this situation and this is not intended to make it hard on any particular group. We can't go to their country. It seems to me that turnabout is fair play. He doesn't say anything about Americans being able to go to any of these countries that he mentioned these doctors are coming from. We are not closing the doors of the United States. We are asking that they live over here long enough to become citizens of New Jersey before they apply for license. If they want to go to New York State and practice a year or two, or three, or four, that is all right. We should like them to become citizens here first.

He speaks about the man in his brother-in-law's office. That is perfectly all right with us, but I don't feel because of an emotional appeal that we should be guided by that alone. I feel if we do have immigration barriers and bars thrown down, we will have an influx. There is no question about that, and I still feel that this is a good thing in spite of our sympathies, be what they may. I think we ought to pass it. (Applause)

The question was called for.

President Snedecor: I will entertain a motion that we move the previous question.

Dr. Quigley: I so move.

The motion for the previous question was regularly seconded, was put to a vote, and was carried beyond the number of votes required (Two-thirds).

The motion for the adoption of Dr. Murphy's resolution was put to a vote and was carried.

Dr. Abram Weiss: May I ask one question? If such a law were passed, would that prevent some renowned scientist who didn't intend to practice over here but to come over here to demonstrate—suppose some surgeon from the other side would bring—he would not be allowed to practice.

President Snedecor: It would not apply to that.

Let's get this done very shortly now. The Board of Trustees has asked to meet with distinguished guests who are coming here. Dr. Bishop is here representing the State of Pennsylvania. The President-Elect of the State of New York and the President of the State of Connecticut are going to join with us in a meeting as soon as we finish here.

71. Specialists Lists in Telephone Directories

Dr. George M. Levitas (Bergen County): As you know we have tried to classify our specialists according to a definite standard. The New Jersey Telephone Company has issued a yellow sheet as its supplement in Bergen County with which I am well acquainted. A perusal of that sheet will show that for fifty cents a month any physician can classify himself as any kind of specialist he prefers to call himself.

I was surprised to find a goodly number of men classified by the telephone company, in Bergen County, who have absolutely no hospital connections. I spoke to a telephone representative and he said, "We feel we can publish anyone's name who is licensed to practice medicine, according to his own selection as to specialty, regardless of what the medical profession feels about it."

I asked, "Don't you feel you owe it as a courtesy to the hospitals to inquire whether they are on their staffs?"

"No, they pay for it, so they are entitled to it."

That is a very serious situation in Bergen County where so many people come from New York to make their permanent homes, and I feel that these large utilities are at least honest in their intentions and presumably they may be believed; that when the telephone company publishes the name of an individual in its book, we ought to think their representations are correct.

I, therefore, move that the Public Relations Committee be requested to communicate with the telephone company in reference to deleting these names unless properly classified.

President Snedecor: Is the motion seconded?

Dr. Londrigan: I second the motion.

President Snedecor: Dr. Londrigan seconds the motion that the Public Relations Committee be instructed to get in touch with the telephone company to have the listing deleted unless properly vouched for by the medical body.

Dr. Leslie E. Myatt: I should think it was proper for the County Medical Society to do something about it, if any member of the Society is doing something he should not do. They should take it up with him. I don't think we should go to the telephone company about it. They are out to make all the money they can, and it isn't up to us to lower our-

selves by doing that. The individual physician should be consulted.

The question was called for.

PRESIDENT SNEDECOR: The question is that the Public Relations Committee be instructed to contact the telephone company to have these classified directories changed unless there is some recognized standard of approving them.

The motion was put to a vote. There was a division of the house and a rising vote was called for.

MEMRER: I could tell you a lot about specialists, and I happen to be a general practitioner.

PRESIDENT SNEDECOR: I am sorry, Doctor. You are out of order. I am taking the vote. Will you please stand, all in favor of the motion? All those opposed. I declare the motion carried.

The motion was carried, 57 voting in favor, and only fifteen or twenty opposed.

72. HONORARY MEMBERS

DR. THOMAS K. LEWIS: Going back to the Honorary Members, I should like to ask the Reference Committee handling the Honorary Memberships' standing to answer a rather pertinent question. Does the fact that an Honorary Member is also a paying, Active Member of the County Society alter the legality of his holding a position in the State Society?

PRESIDENT SNEDECOR: That question I would refer both to the Committee on Honorary Membership, and the Committee on By-Laws which is proposing an amendment, to study. Is there objection? Hearing none, it is so ordered.

73. PURE FOOD AND DRUG ACT

DR NORMAN W. BURRITT (Union County): There is a perfectly good reason for this resolution which I will introduce, because there is something of a misunderstanding concerning the report that the Board of Trustees asks an instruction for our Delegates to the American Medical Association to take this matter up at the oncoming convention; and I understand from the Secretary of the Board of Trustees that no such instruction has been given to the Delegates to the A. M. A.

I, therefore, offer this resolution,

"That The Medical Society of New Jersey reaffirm the actions of this body of the past three years in opposition to the permissive and pernicious provisions of the Copeland Food and Drug Bill; and instruct our delegates to the approaching convention of the American Medical Association to bend their efforts to develop a constructive program in the American Medical Association toward preservation of the mandatory provisions and the distribution of responsibility of the Food and Drug Law of 1906."

PRESIDENT SNEDECOR: Dr. Burritt, excuse me. According to my understanding, this House took action during the past three years on the Copeland Bill, and it is my understanding that the Copeland Bill has been greatly changed in its present consistency. Is that correct?

DR. BURRITT: That is correct but I specify the permissive features.

PRESIDENT SNEDECOR: The action of the House of Delegates relating to the previous Copeland Bill doesn't apply to this one?

DR. BURRITT: I am sorry, but it does. Dr. Read and Dr. Kler will bear me out in that after going over it carefully. The amended Copeland Bill as passed by the Senate and now in the House for consideration, as it relates to our objection to the Copeland Bill—there has been absolutely no change at all.

PRESIDENT SNEDECOR: Will you state it again?

Dr. Burritt's resolution was read from the record. (See p. 150 of the typed record.)

Upon motion regularly made by Dr. Burritt and seconded by Dr. Read, it was voted that the resolution offered by Dr. Burritt be adopted. (Action, Jour. A. M. A., June 26, p. 2219.)

PRESIDENT SNEDECOR: Is there any New Business? This is your last opportunity to introduce New Business.

73 A. SPECIALISTS LISTED IN TELEPHONE BOOKS

DR. L. F. MELONEY (Passaic County): I want to know how the telephone company is to decide who is to be classified as a specialist. (See Sect. 71.) It is childish to ask the company to be the judge. It cannot be the determining factor in this. We should offer a committee, or have the component societies do something to help the telephone company fix up its yellow sheet.

PRESIDENT SNEDECOR: Is there anything else to come before us? If not, I will entertain a motion that we adjourn.

DR. WOOD: I so move.

The motion was regularly seconded, was put to a vote, and was carried; and the session adjourned at four forty-five o'clock.

THURSDAY AFTERNOON SESSION, APRIL 29, 1937

The final session of the House of Delegates convened at twelve forty-five, President Snedecor presiding.

President Snedecor: We will come to order, please, gentlemen.

73 B. Annual Meeting of 1938

Dr. Lancelot Ely: The Nominating Committee, as I understand it, did not make any reference to the time and place of the meeting next year. Dr. Newcomb, having left this morning, wished me to call it to the attention of the House of Delegates and he recommended that we meet here in Atlantic City, in 1938, and I so move.

Action, Sect. 90.

President Snedecor: Dr. Ely, you took the words out of my mouth. I will give you a few minutes to think about it, so that we don't rush it through too quickly, and we will take it up under New Business, if that is agreeable to you.

We will take up today the consideration of reports of the Reference Committees first and then Special Reference Committees, and such other business as may properly come before this House. The session will continue until we finish, or until the President expires. If you get sufficiently hungry, it will add to expediting the process of the meeting.

We will hear first a report from Reference Committee A, and as a general thing I should like to request the Chairmen of these committees to take their reports up serially, according to the action they wish taken on their recommendations.

74. Reference Committee A, on President's Report

(From Sect. 9)

74 A. Dr. Edward W. Sprague, chairman of Reference Committee "A", read the report of the Committee on the President's Report, as follows:

REPORT OF REFERENCE COMMITTEE "A"

Report of the President Spencer T. Snedecor, M.D.

During 1936-1937 the New Jersey Medical Societ yhas accomplished many things. The President's Report gives a resumé of work done and recommendations for continued activities.

The President calls attention to the importance of the Welfare Committee to the Society; that each year more work is accomplished. The dangers to organized medicine at this time are many and require eternal vigilance and the support of every member of the Society.

He calls attention to the needs of the practical support of the Society members, both in dues and in actions. He calls the individual member's attention to the necessity of preserving profitable medical practice and that he should understand the physician's relationship to the Social Security Legislation. The Society emphasizes preventive medicine by the family doctor and on this point the Federal Social Security projects are helpful. The interest in this subject has been consumated in the "Handbook of Preventive Procedures," which was issued as a supplement to the Journal of March, 1937.

He cites the good work of Dr. Stanley Nichols, chairman of the Public Health Committee, and Dr. Frank Overton, in developing and completing this Handbook. The President believes; "That this unique Volumne will be consulted far and wide as a model outline for the preventive medical practice of doctors at large."

The President stresses the need and value of increasing our interest in Public Relations in every way; "in this day, the philosophy of the practice of medicine in the interest of our people requires interpretations as to the public at large."

Plans for medical relief of the indigent are based on the original New Jersey E. R. A. Plan and the State Finance Assistance Commission has approved the principles.

The President believes the Hospital Staff Relationships have improved and calls attention to the many noteworthy conclusions from the reports of the Hospital Survey of the State.

The President's Cabinet comes in for commendation and surely in this manner work has been delegated to the President Elect and the Vice-Presidents in such a manner as to cover the component Societies adequately.

The President closes his report with four important recommendations:

1. That the tested reorganization and integration of the various committees under the Welfare Committee be approved.

2. That the Public Relations program as now getting under way, with plans for contacts and the spread of medical information, be endorsed.

3. That the general Public Health policies, as reported by the individual advisory committees, be supported and approved.

4. That the general policy of building up both State and County society organizations, in order to more effectively preserve our practice and carry out our health responsibilities, be encouraged.

This Reference Committee endorses the President's Report in each detail. We particularly stress:—

1. The continuance of a President's Cabinet with comprehensive allocation of work from the President's office so that each component Society will be made aware of the needs of organized medicine and of the desire of the State Society to render all possible assistance in working out the individual county problems.

2. Continued effort must be made to bring about an understanding between the State authorities and the Medical Society of New Jersey whereby the State realizes its financial responsibility to the physician for the care of the indigent and we should follow through on our original plan of medical relief for the indigent.

Finally, the President is to be commended for his vision in organization and mobilization of the Society this year and for his untiring efforts and accomplishments. He is deserving of the thanks of every member of the State Medical Society.

Dr. Sprague: Mr. President, we ask you to accept the Report of Reference Committee A on the Report of the President, and I move the acceptance and adoption of it.

The motion was seconded by Dr. Herbert W. Nafey, was put to a vote, and was carried.

74 B. Executive Officer's Report

(From Sect. 10)

Dr. Sprague read the Report of Reference Committee A on the Report of the Executive Officer, as follows:

Report of the Executive Officer,
LeRoy A. Wilkes, M.D.

The report of the Executive Officer shows that a large amount of work has been accomplished during the past year.

One of the most important duties of the Executive Officer is to make personal contacts with the individual physician, component societies, health agencies, hospitals and the public at large. The value of the contacts is very important and the Executive Officer has fulfilled this duty well.

He calls attention to the importance of the various component societies' bulletins and also to the needs for the component societies to have available records and that the source material of Committee reports, such as photographs, pamphlets, local reports, newspaper clipping, et cetera, should be saved and sent to the successors or to the Executive Offices where they may be preserved for future reference. This is an important subject.

The Executive Officer and the Editor are working in close coöperation, especially in the fields:

1. Standards of medical service.
2. Hospital relationships.
3. Coöperation under the Social Security program.
4. Popular publicity regarding medical services.

He calls attention to the one high quality standard of medical service to which all physicians assent; and he also calls attention to the Public Health Handbook which presents "the special preventive and protective developments in medical practice which will more and more become his obligation and function. Preventive medicine is the field of practice not yet fully developed by the family doctor. Its development will bring to him increased opportunity, satisfaction, and dividends."

The value of the hospital survey is stressed, also coöperation "in the approved medical services demanded under the National Social Security program."

Public Relations is a vital activity. The attitude of the physicians is often misunderstood. The Executive Officer stresses our needs to maintain a friendly attitude coupled with interest and desires to know more about the work of other community groups. This begets a like interest in the medical profession and its plans and programs.

The report is concluded by calling attention to the function of the Executive Offices as a center where any member or organization may obtain information and advice in any branch of medical service.

Altogether the report is entirely satisfactory, and shows a very comprehensive understanding of the individual physician's viewpoint and of the viewpoint of organized medicine. We feel that the duties and scope of the activities of the Executive Officer must be reviewed each year so that the fields of action will always be within the ideals and practices of organized medicine.

Upon motion made by Dr. David H. Ulmer, seconded by Dr. Lancelot Ely, it was voted that this section on the report of the Executive Officer be accepted and adopted.

74 C. Incoming President's Address

(From Sect. 60)

Dr. Sprague read the Report of Reference Committee A on the Address of the In-Coming President, Dr. William G. Herrman, which was as follows:

The address of the incoming President, William G. Herrman, M.D., states his intention of continuance of the practice of the committees which have been functioning during the past year. He also plans the further development of policies in the various committees along the lines of the work done this year.

He desires the coöperation of his Cabinet, made up of the President-Elect, the Vice-Presidents, Chairman of the Board of Trustees and the Chairman of the Welfare Committee.

He desires to increase the understanding by the physicians of the Social Security Act so that he may better coöperate with the Government agencies in the medical aspects of the problem.

He hopes for greater correlation of the Medical and Administration departments of the hospitals.

He hopes to eliminate the objectional features of the present Workmen's Compensation Act.

He states the need of better facilities for the cancer case.

He urges the private physician to recapture certain phases of preventive medicine.

He hopes to extend the work of the Public Relations Committee and endorses the two-fold plan of the Nursing Education Committee.

In a short time the Society may expect a more detailed plan for the year's work.

Our incoming President has a broad grasp of the present days problems and a fine vision of our future needs. Let us all give him every possible assistance for the coming year of his high office.

Dr. Sprague moved the acceptance of the reference committees report on the remarks of the Incoming President. The motion was seconded by Dr. David B. Allman, and carried.

.74 D. Finance and Budget Committee

(From Sect. 12)

Dr. Sprague read the Report of Reference Committee A on the Report of the Finance and Budget Committee, as follows:

This Committee realizes the value of the expanding program of activities of The Medical Society of New Jersey, and the benefits therefrom, which ultimately accrue to the individual physician throughout the State.

After hearing from all interested, and careful consideration by this Committee, the following recommendations are made:—

1. That the budget as presented by the Finance and Budget Committee totaling $66,680 be approved.

2. In consideration of the needs of the budget and of the financial status of the Society, we approve the recommendations of the Finance and Budget Committee that the dues of the State Medical Society be $15 per member for the coming year.

The Chairman of the Finance and Budget Committee, Dr. North, has given unlimited time and meticulous attention and care to the tiresome details of this work.

Dr. Sprague: Mr. President, the Report of the Finance and Budget Committee and the Report of the Treasurer, I think should be adopted after both have been read or considered after both have been read.

President Snedecor: We will have it that way.

74 E. Treasurer's Report

(From Sect. 11)

Dr. Sprague read the Report of Reference Committee A on the Report of the Treasurer, as follows:

TREASURER'S REPORT

The Committee has analyzed the report of the Treasurer and find that the Treasurer has an understanding of the financial status of the Society, and that he has given unlimited time and attention to the many details of his office.

We approve of the figures which we have so analyzed.

The Committee after due consideration appreciate the fact that honest confusion may take place in interpreting the report of the Treasurer and of the Finance and Budget Committee because:—

1. The budgetary year is from June 1st to May 31st.

2. The fiscal year is June 1st to May 31st.

3. The assessment year is from January 1st to December 31st.

4. The sum presented to the Society as remaining balance in the bank on May 31st of each year is a suspense account, which is the sum from which all expenditures from May 31st to December 31st must come.

5. The budget figures which are drawn against this balance are a new and increasing budget over the budget under which this money was assessed and accumulated.

Correlating the assessment year with the fiscal years—Therefore, we urgently recommend to the Trustees and the House of Delegates for their consideration, that a study be made of this whole problem so that changes correlating the assessment and fiscal years may be brought about to remedy this confusion.

System of Accounting:—Again, at the suggestion of Dr. North and Dr. Marsh, we advocate that the Trustees and the House of Delegates study the problem of arranging for a system of accounting, to be under the supervision of the Treasurer and the Finance and Budget Committee. Detail work to be carried out in the Executive Offices.

Respectfully submitted,

Edward W. Sprague, *Chairman*
George M. Knowles,
J. P. Pregnall,
Samuel L. Salasin,
H. Burton Walker.

Dr. Sprague: Mr. President, we submit the Report of the Reference Committee on the Report of the Treasurer and the Report of the Finance and Budget Committee, for your consideration.

President Snedecor: Thank you, Dr. Sprague.

Dr. Ralph Hollinshed: I move that these two sections of the Report of Reference Committee A, approving the Report of the Treasurer and his recommendations, and the Report of the Finance and Budget Committee, be accepted and adopted.

The motion was seconded by Dr. James A. Fisher, was put to a vote, and was carried.

President Snedecor: Does that complete your report?

Dr. Sprague: Yes.

President Snedecor: I would entertain a motion that the full Report of Reference Committee "A" be adopted as presented by Dr. Sprague.

Dr. Walter J. Farr: I so move.

The motion was seconded by Dr. Samuel L. Salasin, was put to a vote and was carried.

75. REPORT OF REFERENCE COMMITTEE "B"

PRESIDENT SNEDECOR: We will now have the Report of Reference Committee "B", Dr. Lancelot Ely, Chairman.

75 A. TRUSTEES

(From Sect. 13)

DR. LANCELOT ELY: Mr. President and Delegates: At a late date we were asked to consider the Report of the Board of Trustees. We also considered the Report of the Secretary, the Report of the Judicial Council, the Report of the Committee on Insurance, the Report of the Advisory Committee to the Woman's Auxiliary, and the Report of the Sub-Committee on Public Relations.

The members of Reference Committee "B" read over carefully all the reports as printed in the Journal, the Chairman requesting each member to cover each before he came to the convention.

Report of Board of Trustees

We approved at a late date the action of the Board of Trustees taken April 26, 1937, pertaining to the retirement of Dr. J. Bennett Morrison as Secretary of The Medical Society of New Jersey. Mr. President, I submit this report on the Board of Trustees as follows:

Dr. Eagleton moved that the Board of Trustees recommend to the House of Delegates, in view of the fact that Dr. Morrison is retiring as Secretary, and in view of his length of service, that he be voted an annual honorarium of $1500, his present salary; and it is further recommended that the detail work of the office of Secretary be done by the Executive Offices in Trenton. (Sect. 13.)

Motion seconded by Dr. Carrington, and unanimously carried.

Upon motion made by Dr. H. Roy Van Ness, seconded by Dr. Samuel Alexander, it was voted that this section of the Report of Reference Committee "B" on the Trustees be accepted and adopted.

75 B. SECRETARY'S REPORT

(From Sect. 18)

DR. ELY: The Report of the Secretary, Dr. J. Bennett Morrison, is approved. The Committee fully realizes and appreciates the value and the valuable work that Dr. Morrison has been and has done for this Society during the fifteen years he has given undivided attention to this Society.

DR. LESLIE E. MYATT: I move that this part of the report of Reference Committeee "B" be accepted and adopted.

The motion was seconded by Dr. Lyon, was put to a vote and was carried.

PRESIDENT SNEDECOR: Please don't hesitate to speak if you wish to do so. I will run along rapidly unless you object and want discussion.

75 C. JUDICIAL COUNCIL

(From Sect. 27)

DR. ELY: The Report of the Judicial Council and separate Councilors has been reviewed. It came to the attention of the committee that the Board of Trustees (if I am incorrect, Dr. Snedecor, correct me)—that it did not seem advisable to consider the redistribution of the Districts at this time, so therefore, we did not accept or consider the recommendation of the redistribution of Judicial Districts. The discontinuance of annual district meetings was approved by the Reference Committee "B", and I move the adoption of this report, Mr. President.

It was moved by Dr. Burritt and seconded by Dr. Londrigan that this part of the report of Reference Committee "B" be accepted and adopted. The motion was put to a vote and was carried.

75 D. INSURANCE COMMITTEE

(From Sect. 31)

DR. ELY: The Report of the Committee on Insurance is worthy of close consideration by all members of the Society. The new features added to the automobile insurance plan were considered carefully. On account of the importance of this insurance and the expressed objections by certain members of the State Society to the present set-up of group automobile insurance, this committee recommends that automobile group insurance should be further considered by the Board of Trustees before it is recommended to the House of Delegates.

I move the acceptance and adoption of this section of the Report of Reference Committee "B", Mr. President.

The motion was seconded by Dr. Wood, was put to a vote, and was carried.

PRESIDENT SNEDECOR: I am sorry, it has been passed, Dr. Pinneo. Do you wish it reconsidered?

DR. PINNEO: My interest in group insurance is such that I should like an expression of the House of Delegates on the general principle of group insurance.

PRESIDENT SNEDECOR: I don't see how that can come up at this time, Dr. Pinneo. Will you proceed, Dr. Ely?

75 E. WOMAN'S AUXILIARY

(From Sect. 55)

DR. ELY: The committee realizes the work that is being done by the Woman's Auxiliary. We have read carefully the Report of the Advisory Committee, and the report is approved without any recommendations.

Upon motion made by Dr. Farr, and sec-

onded by Dr. Knowles, it was voted that this part of the Report of Reference Committee "B" be accepted and adopted.

75 F. Public Relations Committee

(From Sect. 59.)

Dr. Ely: The Report of the Sub-Committee on Public Relations was carefully reviewed. We realize that this committee has done a wonderful work during this year. It is a committee work that is admirable. We request that all members reread that report for their own information and act accordingly after they have read it. We especially recommend the action in regard to press publicity and press editorials from a medical viewpoint.

This committee recommends that the portion of this report relating to finance be referred and considered by the Finance and Budget Committee.

I so move the acceptance and adoption of this report.

The motion was seconded by Dr. Watson B. Morris, was put to a vote and was carried.

Dr. Ely: That is the end of that report. It is signed by the full committee: Lancelot Ely, Chairman; J. Howard Hornberger, Reuben Sharp, J. Wallace Hurff, Harrison B. Wilson.

Dr. Knowles: I move that the complete Report of Reference Committee "B" be accepted and adopted.

The motion was seconded by Dr. Walker, was put to a vote, and was carried.

76. Report of Reference Committee "C"

Dr. Edgar A. Ill, Chairman

President Snedecor: We will now hear the Report of Reference Committee "C", Dr. Edgar A. Ill, Chairman.

76 A. Publication Committee

(From Sect. 23)

Dr. Ill read the Report of Reference Committee "C" on the Report of the Publication Committee, as follows:

REPORT OF THE PUBLICATION COMMITTEE

After careful consideration of the report of the Publication Committee, Reference Committee "C" recommends that all the suggestions for extending the activities of the Editor of The Journal be concurred in.

During conferences with the Chairman, the following points were developed:

1. The amount of money allocated in the budget for printing and distributing the Journal has no relation to the income produced by the advertisements.

2. The cost of advertising space is determined by the Coöperative Medical Advertising Bureau of the American Medical Association after prolonged study of supply and demand for each of the State Journals.

3. The type of acceptable medical advertisements is determined by the standards of the A. M. A. Council of Foods and of the Council on Pharmacy and Chemistry; and the standards for other advertisements are based on the often reiterated instructions of the House of Delegates to keep The Journal a scientific and economic house organ accepting only dignified advertisements having some relation to the practice of medicine.

The Reference Committee believes a determined effort should be made to increase the advertising matter in the Journal in conformity with the standard as having been stated above.

Within these limitations we have great confidence in the scientific and business judgment of the members of the Publication Committee and recommend that the details be left to their discretion.

This has been a clear, concise, and understandable report of the activities of the Journal, which is the structure promoting the welfare of organized medicine.

Upon motion made by Dr. Ulmer, seconded by Dr. Mann, it was voted that the portion of the Report of Reference Committee "C" pertaining to the Report of the Publication Committee be accepted and adopted.

76 B. Program and Arrangements

(From Sect. 35)

Dr. Ill read the section of the Report of the Reference Committee "C" on the Report of the Committee on Program and Arrangements, as follows:

The Reference Committee has read the report of the Committee on Program and Arrangements, and attest to the complete and most interesting scientific programs and meetings.

Dr. Ill: I would suggest that the rest of these be considered, together with the one I have just read, as one, if that is possible. There can be no argument about it.

President Snedecor: The Chair will accept your suggestion.

Dr. Ill read the balance of the Report of Reference Committee "C", as follows:

76 C. Scientific Work

(From Sect. 36)

III. Report of the Committee on Scientific Work

The Reference Committee wishes to acknowledge to the Committee on Scientific Work that its aims and purposes as judged by those attending the Annual Meeting have been complete.

76 D. Scientific Exhibits

(From Sect. 37)

IV. Report of the Committee on Scientific Exhibits

The Reference Committee wishes especially to comment on the excellence of the scientific exhibits. The committee feels that the suggestion, as made by the Scientific Exhibit Committee, be carried out.

76 E. Welfare Committee

(From Sect. 38)

V. Report of the Welfare Committee

The Reference Committee has read the report of the Welfare Committee and wishes especially to comment on the large amount of work which has been done. They also wish to comment most favorably on the fact that this Welfare Committee has organized so as to hear at their meetings the reports from every part of the State. This the Reference Committee believes to be especially valuable; also the invitation to and the presence of members of the county societies who are not members of the Welfare Committee. This is most helpful.

76 F. Sub-Committee on Legislation

(From Sect. 41)

VI. Report of the Sub-Committee on Legislation

The Reference Committee has read the report of the Sub-Committee on Legislation and wishes especially to comment on the successful activity of this committee. Apparently the work has been light, but the Reference Committee feels a great deal of effective work was done by this sub-committee which does not necessarily show in this report.

(Signed) Edgar A. Ill, *Chairman*
Byron G. Sherman
A. H. Coleman
Henry Spence
Walter B. Mount

Upon motion made by Dr. Stahl, seconded by Dr. Londrigan, it was voted that the sections of Dr. Ill's report not already voted upon be accepted and adopted.

Upon motion made by Dr. Londrigan, seconded by Dr. Hough, it was voted that the Report of Reference Committee "C" be accepted and adopted as a whole.

77. Report of Reference Committee "D"

President Snedecor: We will now hear the Report of Reference Committee "D", by Dr. Leslie Myatt.

Dr. Leslie Myatt: Reference Committee "D" considered the reports of the Committee on Delegates to the American Medical Association, and there was no comment except that of commendation.

President Snedecor: Pardon me, Dr. Myatt, but in order to facilitate things, if there are no controversial things in your report, perhaps we can take all the sections at once.

77 A. Honorary Membership

(From Sects. 22, 25 A, 26, 72)

Dr. Myatt: The only comment we had to make on the five reports concerned the Committee on Honorary Membership. It seemed to our committee that this was a matter for consideration by the By-Laws Committee.

Our impression was that, provided no consideration had been given this in the By-Laws, then an Honorary Member could not serve a dual function. He would either have to be an Honorary Member, pay no dues, and take no active part in the Society; or he would be an Active Member. It seemed rather illogical that a member could serve in a dual rôle, and it was considered so by our committee.

I am not familiar enough with the By-Laws to say. It would seem to me this is probably covered in the By-Laws. If it isn't, definite arrangements should be made whereby this could be taken care of in our Constitution.

That is my report.

President Snedecor: For a point of information, the Chair would like to ask the Committee on Constitution and By-Laws if they are considering the same subject.

Dr. Alexander: In my report yesterday I submitted an amendment to the Constitution to clarify that question. It was presented yesterday and will be voted upon at the Annual Meeting next year.

President Snedecor: Then I rule it is in order to consider the interpretation at this time as considered in Dr. Myatt's report. Is there anything further, Dr. Myatt?

Dr. Myatt: That is all.

Dr. Herbert W. Nafey: I move the acceptance and adoption of this report of Reference Committee "D".

The motion was seconded by Dr. MacMillan.

Dr. Londrigan: It should be required that it be put in the record that that be on the record of this Society and in the transactions, that their impression is just as he has so stated.

President Snedecor: Is the statement rendered by Dr. Myatt in the record?

The Reporter: It is.

President Snedecor: She says that it is.

Dr. Londrigan: Thank you.

President Snedecor: Are you ready for the question?

The motion for acceptance and adoption of the Report of Reference Committee "D" was put to a vote and was carried.

78. Report of Reference Committee "E"

President Snedecor: We will go on to Reference Committee "E", Dr. William H. Areson, Chairman.

78 A. Sub-Committee on Public Health

(From Sect. 39)

Dr. Areson read the report of Reference Committee on the Report of the Sub-Committee on Public Health, as follows:

As usual, Dr. Nichols presents an exhaustive, interesting survey of a vast amount of public health problems, which, as his committee reports, "has made the past year an overwhelmingly crowded one for the Public Health Committee and others" responsible for State and county health problems. Their slogan "Every Physician's Office a Health Center", carried to a definite conclusion, will preserve the family physician and answer the challenge of Federal Health Insurance, and other challenges facing our profession by social welfare and other groups. This committee stresses the necessity of the keen loyalty of every member of the State Society if real progress is to be made this coming year; and this Reference Committee strongly urges the help of every member in the effort to assist both the individual physician's private work on preventive medicine and the County Society's organized program for preventive medicine.

This committee has endeavored to bring into concrete being three essential steps:

1. *The Handbook of Preventive Procedures.*—This handbook, comprehensive, definite as it is, compiled by men of outstanding ability in their chosen specialties, should be of lasting benefit to our members. This book should be retained as a handy reference book on preventive medicine.

2. *Post-Graduate Education.*—The making of a post-graduate course available to our members must result in improving the ability of physicians to deliver better preventive medical service to his patients.

3. *Distribution of Improved Medical Services.*—The committee emphasizes that a clearer understanding of preventive medicine by the physician, and his willingness to better his knowledge of preventive medicine, will leave less residue to be thrown back upon his county society.

The five recommendations of this committee as embodied in their report are clear and concise, and essential for the preservation of the private practice and also to render better medical services to the citizens of our State.

A careful study of Dr. Nichols' report by every member of this Society is essential to fully comprehend the diversity and character of the committee's program; also this committee explains and emphasizes the seriousness of the situation confronting every medical man in the State.

We commend and endorse this report, and request the full coöperation of every member of our Society with this most efficient committee, which without question, has more than done its bit in the effort to make "every physician's office in New Jersey a Health Center for the practice of preventive medicine".

Dr. Areson: May I recommend that, and ask the adoption of the report on Public Health?

Upon motion made by Dr. Sprague, seconded by Dr. North, it was voted that the section of the Report of Reference Committee "E" pertaining to the Report of the Sub-Committee on Public Health be accepted and adopted.

78 B. Cancer Control

(From Sect. 47)

Dr. Areson read the portion of his report dealing with Cancer Control, as follows:

A careful study of this committee's report is essential for a full realization of the thought, time, and attention given by them to this serious medical problem.

The program of this committee concerns itself about the education of the physician and the public and the diagnosis and treatment of cancer.

Attention is called to several errors in the tabulation of the findings of this committee pertaining to general hospitals having tumor clinics. We suggest that a thorough survey be made by the Cancer Control Committee in each county. There was some misunderstanding and confusion, and this Reference Committee feels that it must refer it back to the State Welfare Committee for further study.

Upon motion made by Dr. Wood, seconded by Dr. Hawkes, it was voted that the section of the report on Cancer Control be accepted and adopted.

78 C. Child Health

(From Sect. 43)

Dr. Areson read the section of his report on Child Health as follows:

The work of this committee has been principally the furnishing of competent pediatricians, well equipped to present the subject of child health before lay organizations.

We endorse heartily this work of the committee.

Upon motion made by Dr. Burnham, seconded by Dr. Knowles, it was voted that this portion of the report be accepted and adopted. tion of the report be accepted and adopted.

78 D. Crippled Children

(From Sect. 45)

Dr. Areson read the section of his report devoted to Crippled Children, as follows:

As stated in their report, "the chief aim and activity of our committee has been to correlate the work of the crippled children in this State".

The major efforts of this committee have been chiefly directed toward the placing of the care of these children under recognized orthopedic surgeons; and their after-care placed in the hands of nurses whose work is known to the surgeon. In endorsing this report, we too hope that the recommendations of this committee "that the present cordial relations between it and the Commission remain in force so long as the Social Security Program for the Care of Crippled Children remains active".

Upon motion made by Dr. Evans and seconded by Dr. Behn, it was voted that this portio of the report be accepted and adopted.

78 E. Maternal Welfare

(From Sect. 44)

Dr. Areson read the section of his report on Maternal Welfare as follows:

This report shows a steady healthy growth in the development in the care of the maternity patient.

The regular conferences of this group with all physicians interested in obstetrics indicate a very harmonious attitude between the members of this committee and the practicing physician.

The consultation services proved their worth, undoubtedly accounting for the new low maternity rate for 1936,—3.7 per thousand live births as compared with 4.5 for 1935 and 5.9 in 1931, the first year of the committee.

We recommend this report, and feel sure that each county has felt the stimulating influence of the efforts of this active Maternal Welfare Committee.

Upon motion by Dr. Ulmer and seconded by Dr. Sommer, it was voted that this portion of the report on Maternal Welfare be accepted and adopted.

78 F. Mental Hygiene

(From Sect. 49)

Dr. Areson read the section of the report on Mental Hygiene, with one interpolation, as follows: In the second paragraph, at the point indicated, insert: "That statement is made and we feel that lectures and articles on mental hygiene can be effective."

We feel that this report is of exceptional interest and importance to every member of the State Society. As stated in the report, "The object of this Advisory Committee on Mental Hygiene is to promote the active interest of all practicing physicians, not only in the abnormal mental state of patients, but also in the fact that there are *important and extensive mental factors involved in every physical illness.*"

This committee is of the opinion that it cannot fully endorse their proposition that lectures and articles on mental hygiene are relatively ineffective. (Interpolation—That statement is made, and we feel that lectures and articles on mental hygiene can be effective.) In fact, we feel that the family physician does not have to learn any psychiatry actually through clinic work in mental hygiene clinics. For this reason we do not accept their second recommendation (which is that mental hygiene clinics be established and that the family physician learn his mental hygiene there).

A study of this report shows an exhaustive analysis of this question of Mental Hygiene, and presents a clear and comprehensive outline of the problems involved, especially as met up with by the family physician. In this regard, the committee "recommends that the psychiatrists stress that the mental hygiene clinic is a helpful tool to the family doctor, and that it does not compete with his practice".

We wish to congratulate Dr. Plant, and recommend this advisory report which, boiled down, is a plea for improve coöperation between the family physician and the psychiatrist.

Upon motion regularly made and seconded by Dr. Ill and Dr. Fort, it was voted that this Mental Hygiene section of the report of Reference Committee "E" be accepted and adopted.

78 G. Tuberculosis

(From Sect. 46)

Dr. Areson read the section of the report dealing with Tuberculosis, with one interpolation at the bottom of the page, as follows: "However, in this report we recommended the opening of general hospitals for the reception of tuberculous patients, the only controversial issue we have in this most excellent committee's report."

This Reference Committee, satisfied with the efficiency of tuberculin testing and follow-up by x-ray of the teen age group of students, asks for a militant organization within our State Medical Society to demonstrate "our loyalty and belief in such measures". As stated by the committee, it is only by these tests and x-rays that tuberculosis can be recognized in its early stages, the important time to catch the disease.

More prompt and complete utilization of all diagnostic methods is the keystone of this committee's report.

For many years to come, the medical profession will have to maintain a constant vigilance with respect to this disease; and we must keep before ourselves the fact that tuberculosis is still one of our great health problems.

Tuberculosis has seemingly slipped way down in the death column, as compared with degenerative diseases, cancer, etc.; still we must realize that the tuberculosis problem is far from solved. Its inci-

dence is still high in the most productive years of life, and this Reference Committee endorses the work of Dr. Pollak and his associates in demanding more vigorous methods of diagnosis.

There is no panacea for tuberculosis but rather a continued educational and follow-up program throughout the year as is so definitely recommended in the report under review.

(Interpolation, see page 165.)

This committee does not feel it can subscribe to the suggestion that the general hospitals of this State open their doors for admission of tubercular patients. We will refer this question to the State Welfare Committee.

As has been so well stated, "Until the time arrives when Preventoriums are built instead of Sanatoriums, the end will always be just around the corner."

Upon motion made by Dr. Stahl, seconded by Dr. Sherman, it was voted that this tuberculosis section of the Reference Committee's report be accepted and adopted.

78 H. Venereal Disease Control

(From Sect. 48)

Dr. Areson read the section on Venereal Disease Control, as follows:

This new committee, but one whose duties are most important, presents an interesting detailed report of a most vexatious problem, with very worthwhile suggestions.

The eradication of venereal diseases has indeed been hampered by the social aspect of these diseases, which led to secrecy and avoidance of treatment by the infected person. Such widespread and concerted action as advocated by this committee is of paramount importance if we are to make headway against one of the major health problems of today.

We do not feel that we can approve recommendation number one, because of its questionable value. We doubt the advisability of supplying free drugs for cases by the State, and refer this recommendation to the Advisory Committee on Venereal Disease Control for further study.

In recommendation number four, we advise the words "director of" to be changed to "clinicians in", and we think they should be recommended by the State Board of Health for appointment.

In recommendation number six, we do not favor the inclusion of any local medical health officer because it makes it obligatory.

In recommendation number seven, we advise the second part to be deleted, as it seems contradictory.

The proper treatment and the proper control of venereal cases are weighty problems; and the establishing of clinics and other measures as embodied in the report of the Committee on Venereal Disease Control will accomplish much in many ways.

We recommend the report of this committee for its honesty of purpose, its clarity, and its precision.

It was moved by Dr. Irwin and seconded by Dr. MacMillan, that that section of the Report of Reference Committee "E" dealing with Venereal Disease Control be accepted and adopted.

Dr. Mulford: I understand Dr. Areson to say that the Reference Committee was opposed to the State Board of Health's furnishing free the arsenicals and other substances necessary in the treatment of syphilis. If that is brought about, it will certainly work a hardship on many of us who are in general practice of medicine who want to facilitate the treatment of that disease. It has meant a great deal, the fact that the State Board of Health would furnish us free all the reported cases. Working in a manufacturing town, where the people are poor, it has been very, very helpful to us in the treatment of some of the employees of our plants, whose wages are very low, to be able to get these arsenicals and these other ingredients that are necessary for their treatment; otherwise we wouldn't have been able to have carrie don successfully and gotten the negative Wassermanns that are essential.

I feel that that is a very important thing that you are deleting there.

President Snedecor: May I ask Dr. Areson to reply?

Dr. Areson: "Drugs for the treatment of venereal disease be supplied free by the State Department of Health upon request to any physician regardless of the ability of the patient to pay." That is what we took exception to, not "the indigent".

Dr. Mulford: I beg your pardon. I thought you said you were opposed to that.

Dr. Areson: We only doubt, I say, the advisability of supplying free drugs for every case, and we refer it back to this Venereal Control Committee for further study. We do not reject it.

Dr. Mulford: That brings up the point in question. I think many of the people you would think were able to pay are not able to pay. We know them intimately and we find they are not able to pay, and they are too proud to report, or won't report themselves to the Overseer of the Poor to obtain these arsenicals and other ingredients necessary.

Dr. Areson: We don't arbitrarily delete it. We doubt the advisability, and recommend that

it go back to your committee for further study.

DR. B. S. POLLAK: There is an issue before us in relation to this very problem that I desire to call to your attention. I agree with the gentleman from the committee that the provision should be made to furnish these drugs only to indigents; but we have just recommended—our committee has recommended—for favorable consideration, and I have had the pleasure of being assured of its passage—a bill which was recently introduced granting $25,000 to the State Board of Health for the furnishing of pneumonococcic serum to indigents. If we are going to forbid it in one instance and grant it in the other, we are going to be contrary to a policy that ought to govern us in all things appertaining to the medicaments furnished to indigents.

PRESIDENT SNEDECOR: Let me remind you there is a report on the Report of the Committee on Pneumonia Serum to come.

DR. JULIUS P. LEVY: I think it is inadvisable to use the word "indigent"; use the words "those who cannot afford to pay". That would allow for the class of people the doctor just spoke about. There are many people who can't afford to pay, who aren't technically indigent. If we used words of that character, it would allow desirable freedom.

DR. MULFORD: That is the point I want to bring out, that many of the people you are classifying as "indigent" cannot be classed as such, and many of those are people who have been most coöperative and most helpful in helping us clear up the disease.

DR. STANLEY NICHOLS: I think we have some of the answer to this problem in the conference I had yesterday with Dr. Fischelis, of the Pharmaceutical Society, as to whether the drugs are to be furnished to all people in the State regardless of ability to pay. It is the opinion of the U. S. Public Health Service, as was shown in the Venereal Disease Conference in Washington, that unless this is done, the venereal disease problem will never be controlled in this country. That is how it stands on record on this particular problem which is also an economic problem.

When it came up before the State Welfare Committee, I suggested that it be referred to the Interallied Medical Conference, where the pharmacists, our brothers in drugs, will be represented. I feel that if we give medical services to people who can afford to pay for them, we should stand by our brother pharmacists in the principle of furnishing drugs to people who can afford to pay for them, that being the pharmacist's livelihood.

I said to Dr. Fischelis only yesterday, "Would the druggists of this State be willing, in view of the fact that the U. S. Public Health Service and the State Department of Health, as official health agencies, feel it is necessary to have this particular exception to the sound principle of having people pay for their own drugs and medical services furnished in order to control a communicable, infectious disease—should we not get together and, as pharmacists and medical men, state that the principle of furnishing such things generally, drugs or medical services, to people who could pay, is unsound, but this could be agreed to as an exception by the pharmacists of New Jersey and by this profession, in view of the fact that the Public Health authorities feel it is essential to the control of this disease."

So, I should like to have it referred back to the Welfare Committee for study between the pharmacists and the medical profession so they may agree, for the good of the public, to make this exception, but to oppose the principle.

PRESIDENT SNEDECOR: How would you like to leave the report? Shall it stand as read?

DR. ARESON: Yes, because we don't delete this free treatment. We simply doubt—and refer it back to the Venereal Disease Control Committee.

PRESIDENT SNEDECOR: That is an Advisory Committee of the Welfare Committee; and I take it, that will bring it back to the Welfare Committee.

DR. RYAN: I should like to make an amendment. There is one thing you have lost sight of. Regardless of the individual, this is a public health question, and the whole reason for it is to suppress syphilis, and the individual cannot be considered at all. I strongly endorse what Dr. Nichols said. We have to make an exception in this disease, because if we don't, we will never eradicate syphilis. The individual doesn't count a continental, whether he be a pharmacist or a doctor. We have got to eradicate syphilis, and if we don't supply the drugs, we will never do it. It is a public health measure 100 per cent, and should be treated as a public health question and not from the individual viewpoint.

The question was called for.

PRESIDENT SNEDECOR: Do you propose an amendment? Dr. Nichols, will you repeat what you said?

DR. NICHOLS: I am asking the Reference Committee to refer it back to the Venereal Disease Control Committee.

PRESIDENT SNEDECOR: The committee in-

terprets that that recommendation is included in the recommendation of this Reference Committee.

Dr. Areson: Yes, sir.

Dr. Mulford: Dr. Areson made that statement, did he?

President Snedecor: Dr. Areson made that recommendation.

Dr. Areson: May I read it? Speaking of Recommendation No. 1, pertaining to the fee:

"We do not feel that we can approve Recommendation No. 1 because of its questionable value. We doubt the advisability of supplying free drugs for cases by the State and refer this recommendation to the Advisory Committee on Venereal Disease Control for further study."

President Snedecor: That brings it back to the Welfare Committee.

The motion was put to a vote and was carried unanimously.

78 I. Anti-Pneumococcic Serum

(From Sect. 58)

Dr. Areson read the section of the Report of Reference Committee "E" on Assembly Bill 425 (23c), as follows:

Assembly Bill 425 is to provide assistance to needy pneumonia patients and make an appropriation therefor. We heartily endorse the provisions of this bill, and strongly urge the State Society to use every means to further its passage through the Legislature.

Reference Committee "E"

William H. Areson, *Chairman*
Lorrimer B. Armstrong
C. Byron Blaisdell
Elwood E. Downs
Charles H. Lyon

Upon motion made by Dr. Stahl, seconded by Dr. Alexander, it was voted that this portion of the report be accepted and adopted.

Upon motion made by Dr. Ulmer and seconded by Dr. Harry Spence, it was voted that the complete report of the Reference Committee "E" be accepted and adopted.

79. Honorary Membership

(From Sect. 22)

Dr. W. MacMillan: I should like to move for reconsideration of the Report of Reference Committee "D". I think the vote on it was taken without a true realization of what that vote will mean to the Society, and I have just found out that it does not cover the desires of the committee, and I am sure it does not cover the wishes of the Society.

President Snedecor: Will you be specific in explaining why?

Dr. MacMillan: The report of the committee was that there was a question as to whether a man could qualify as an active member and also as an honorary member. The report of the committee was that he could not do so. Now, the significance to the Society is this, that a Trustee, according to the By-Laws, must be elected from the corporate body of the Society. An Honorary Member is not a member of the corporate body of the Society. This would disqualify the Trustees who have been elected, who are also Honorary Members, and this is not the will of the committee, nor is it the will of the Society, I believe.

President Snedecor: Do you wish to make a motion?

Dr. MacMillan: I move that we reconsider the approval of Reference Committee "D" in respect to the adoption of the interpretation of the By-Laws relating to Honorary Members. (Sect. 77 A.)

President Snedecor: We will have to reconsider the whole report.

The motion was seconded by Dr. Walker and was put to a vote. There was a division of the House and a showing of hands was asked for. The motion was carried 44 to 32.

President Snedecor: We will reconsider the Report of Reference Committee "D".

Dr. Londrigan: What was it?

President Snedecor: Forty-four to thirty-two.

Dr. Londrigan: Is that going in the minutes?

President Snedecor: Yes.

Secretary Morrison: Inasmuch as the members of the Hudson County delegation have served notice on the House of Delegates that they intend to appeal that section of our Constitution to the American Medical Association for interpretation, I move that this reference be stricken from the report.

President Snedecor: You now have a motion made by the Secretary.

Dr. Maurice Shapiro: We object to that strongly, that it be stricken from the report. You can record that it was voted down and not accepted by the House, but we want it in the record that this committee did so report. They reported that in their opinion it was not constitutional.

President Snedecor: That is the reason you appeal for——

Secretary Morrison: If Hudson County doesn't want it, I will withdraw it.

President Snedecor: Is there any motion

now to come before this House in respect to a report of Reference Committee "D"? It is completely open for adoption or rejection.

DR. MULFORD: May we ask that the Chairman reread his report?

PRESIDENT SNEDECOR: Will you read this section of the report about which the controversy hinges?

DR. MYATT: I can't read it because I haven't it written down.

Dr. Myatt's report was read from the record. (See p. 162.)

PRESIDENT SNEDECOR: Do you wish to add anything to that?

DR. MYATT: No, not very much. We felt it was rather unfair for our committee to present any report on this at all except as we parenthesized it with the remarks that I gave to the Secretary or that I just told you about. This should be considered more at length—we felt it should be considered more at length before it was turned over to our committee. It hasn't had a sufficient airing for anybody to quite know what it is about, we thought, but if our opinion was requested, it was as I have given. That is all I have to say.

DR. STAHL: I move its adoption, that the Report of Reference Committee "D" be accepted and approved.

The motion was seconded by Dr. Sherman.

PRESIDENT SNEDECOR: It is now open for discussion. The motion is that the Report of Reference Committee "D" be accepted and approved.

DR. WELLS P. EAGLETON: I was out of the room, but as I understand the report, it throws a doubt on the election of myself and Dr. McBride as members of the House of Delegates of the American Medical Association and also as members of the Board of Trustees. Now, of course, you can't have it both ways. You can't take my dues year after year and then, because the House wants to honor me and make me an Honorary Member—they can't say that you can take my dues and because you honor me that you throw me out as an Active Member.

Now, if I hadn't paid dues all these years, I could understand how I could be disqualified, because at that time—perhaps times have changed and perhaps they wouldn't like to honor me now, but at that time they did.

Such a procedure by a Reference Committee to be adopted by this body would show a lack of understanding of the fundamental principles of government. You can't have it both ways.

By the charter I am a Fellow. I am a part of the corporate body, and by my actions through all these years I have been an Active Member, and when they elected me an Honorary Member, I did not shirk my responsibility by saying, "I am an Honorary Member so I don't pay dues." It never entered my head. I wouldn't have accepted an Honorary Membership which would prevent me from being a part of the active operation of this Society in which I have played more or less a prominent part.

This is beneath the dignity of any body of doctors to take advantage of this and, of course, it will fail. Nobody would support such a thing, that would take a man's money, would take his services, would make him by the charter a member of a corporate body, because I am a Fellow, and then turn around and say, "Because in good faith we elected you an Honorary Member, to put a little honor on you, that disqualifies you from occupying positions of trust."

Gentlemen, it is too absurd! (Prolonged applause.)

PRESIDENT SNEDECOR: Please come to order.

I recognize Dr. Walker.

DR. WALKER: Mr. President, I should like to offer an amendment that the adoption of the report of this commitee shall in no way be construed to invalidate the election of Dr. McBride and Dr. Eagleton.

Murmur of protest and cries of, "No, no, no."

SECRETARY MORRISON: That won't do.

PRESIDENT SNEDECOR: Is there a second to that amendment?

DR. ALEXANDER: A point of order. That amendment is out of order. You can't approve of one thing and, by an amendment to it, destroy the meaning of the motion.

PRESIDENT SNEDECOR: Dr. Walker, I shall have to ask you to withdraw your amendment.

DR. WALKER: I will withdraw it.

DR. MYATT: Gentlemen: This is an organization that is composed of gentlemen, men of ethics. That is the nature of it. That is what it is supposed to be. We don't deal in technicalities. I have nothing but the greatest respect and admiration for Dr. Eagleton and Dr. McBride. We must not deal in personalities, and I don't want anyone to think that I am trying—that our committee is trying to do anything that isn't absolutely above board, and our effort was merely an interpretation of a technicality. I think it is a technicality, and I think, and I think my committee agrees

with me, that it should never have come up. I think these things are not advisable or necessary in a body that has the prestige that ours has, and I wouldn't for the world have the two gentlemen think our committee is in any way reflecting on their standing. I want to make myself clear about that immediately.

I will repeat myself and say that this is a matter that should have deliberate and mature consideration before any change is made in the present order of things, and, as I said before, this committee feels that it should be taken up first by the Committee on Constitution and By-Laws, gone over thoroughly, and then, after mature deliberation, if anything is decided to be done on it, it should be done very carefully and very fairly and without any personal bias.

Thank you!

Dr. Lancelot Ely: I am Chairman of the Honorary Membership Committee and made a report before a previous session of the House of Delegates. We realize the condition as it is printed in the Constitution and By-Laws, and our good friend from Hudson called our attention to a paragraph that may be interpreted one way or another.

We accepted the opinion of our friend from Hudson and at a previous session the chairman recommended to the Committee on Honorary Membership and the Committee on Constitution and By-Laws, that they go over this matter. A first reading has taken place in regard to a change in regard to this paragraph, and I think, Mr. President, that that is being handled properly, and I think this is not the place nor the time for this discussion. We either accept Dr. Myatt's report or we refuse to accept it, but the matter of the Constitution and By-Laws is being considered, and it will come before the House for your acceptance or refusal at a later date.

Dr. Myatt: After consulting with the one member of my committee who is present, under the circumstances, feeling that there is a possibility of an injustice being done to two very fine men, I should like to withdraw the report of our committee on the mater of Honorary Membership.

President Snedecor: Dr. Myatt, there is a motion before the House that your report be accepted and adopted by this body.

Dr. Eagleton: Hasn't the Chairman of the committee the right to withdraw his report?

Murmur of protest and cries of "No".

President Snedecor: Not if there is a motion on it.

Dr. Shapiro: A point of order. Once a report has been submitted, that report must be published and received as a transaction of the House. This House does not have to adopt it. We can reject it, but that must be in the record that it has been presented.

President Snedecor: There is a motion before the House that has been regularly moved and seconded, on the acceptance and adoption of the Report of Reference Committee "D". I would rule that that be open for amendment or else we can vote on the question.

Dr. Quigley: A point of order. The committee has the right to withdraw its report before it has been acted upon. It has the privilege of withdrawing its report. As I understand it, Dr. Myatt has a perfect right to do that.

Dr. Shapiro: May I answer that, Mr. President? The report has already been accepted. We are on reconsideration. This has once been presented to the House. Now we are reconsidering it. The minutes will have to show reconsideration.

President Snedecor: The Chair will rule since this report has been presented and a motion has been made for its acceptance and adoption, action must be taken upon this motion. Are you ready for the question?

Dr. Londrigan: Wait a minute! I want to take exception to Dr. Eagleton's remarks. He and I are friends for twenty-five years. He said Hudson County couldn't disqualify anybody who was nominated by the Nominating Committee and then elected by the body. Hudson County did not do this. Hudson County did not write your By-Laws or your Constitution, but in your Constitution and By-Laws it specifically states that a man who is an Honorary Member cannot be a member of the corporate body. Dr. Eagleton deserves all the honors that you and we have placed upon him, and we are glad he has them, and so with Dr. McBride. It is not a personal proposition with Hudson County. He was a Fellow before he was an Honorary Member, and when he becomes an Honorary Member, your By-Laws and/or your Constitution distinctly state he cannot be a member—and have it noted please on these records—state that Hudson County did not do this. Dr. Eagleton, your own Society made these By-Laws.

Dr. Eagleton: May I ask that my remarks pertaining to Hudson County be eliminated from my remarks? (Applause.)

Dr. Londrigan: Thank you, Dr. Eagleton. I thank you.

President Snedecor: Gentlemen, we have

a main motion before the House on the acceptance and adoption, and——

DR. STAHL: It was ruled yesterday an Honorary Member cannot be a member of the corporate body. It does not say a member of the corporate body cannot be an Honorary Member. (Laughter.) ——and a member of the corporate body, by being a Fellow——

DR. LONDRIGAN: It says he "shall" not be, not "may".

DR. READ: As I see the situation now, we have a motion before us to either adopt or reject and therefore reflect the opinion of this House of Delegates. We have a report of a committee. It is the opinion of five members. It does not of necessity reflect the opinion of this House of Delegates, and until we have a majority vote on either rejection or adoption of this report, I don't see that any exception can be taken to it, and I should think this would be the time to have a vote on this.

The question was called for.

DR. SPRAGUE: May the motion be restated so that we will understand the essence and substance of what is before us for deliberation?

PRESIDENT SNEDECOR: I shall be glad to state it. The motion before the House is——

DR. MARSH: May I inquire if this motion is passed as amended?——

PRESIDENT SNEDECOR: It has not been amended.

DR. MARSH: I thought you said it had been amended.

PRESIDENT SNEDECOR: The motion before the House is for the acceptance and approval of the Report of Reference Committee "D" as presented by the Chairman of that committee, Dr. Myatt. Are you ready for the question?

DR. ALEXANDER: Mr. President and Delegates: That report, as I get it, is for the approval and acceptance of what it says and that, to me, clearly means that if we approve that report, it will go off from this House of Delegates that Dr. Eagleton and Dr. McBride are not eligible to hold any position except that of Honorary Members. I think that is not the interpretation of the Article on Honorary Membership.

This matter came up yesterday and in Dr. Ely's report in this House of Delegates, and this House concurred in what Dr. Ely said, and approved his interpretation of that Article, and I think this should be voted down.

PRESIDENT SNEDECOR: Let's get on. We are discussing a very technical point. Are you ready for the question?

DR. RYAN: Is it in order to make an amendment? I would amend that this be referred back to the Constitution and By-Laws Committee with instructions to amend it. That is all there is to it; otherwise they will be afraid to make that report.

Vigorous murmurs of protest.

DR. RYAN: I don't know whether it is parliamentary or not, but I put it up to the Chair to decide.

Several requests were made for a restatement of the motion.

PRESIDENT SNEDECOR: You may have it. The motion is, Doctor, that this House of Delegates accept and approve the report as given by Dr. Myatt.

The question was called for and the motion was put to a vote and was lost.

PRESIDENT SNEDECOR: Now, Dr. Myatt, do you wish to make any recommendation in regard to your report? I wish to give Dr. Myatt the opportunity of——

DR. RYAN: The point taken by the man is well taken. It is part of the By-Laws. My point is to have the By-Laws amended so an Honorary Member——

PRESIDENT SNEDECOR: The Chair can tell you that that it in due process of being done.

DR. RYAN: All right.

DR. ELY: The amendment of the Constitution is being cared for by the Committee on Constitution and By-Laws to cover this very issue.

PRESIDENT SNEDECOR: Please let us get this clear before the House. I am asking Dr. Myatt if he wishes to say anything in regard to this.

DR. MYATT: I don't think this should ever have come up, myself. This has brought on more personal feeling than was indicated or necessary. I think and I would very much advocate, and my committee member who is present agrees with me, that this matter should be referred to the Committee on Constitution and By-Laws, and have it studied impersonally and intelligently and referred next year to us here at this meeting, and we can then act upon it as we see fit. In the meantime, it is the feeling of Reference Committee "D" that the things that are existing at present should remain the same. There has never been any thought of depriving any member of any privilege which he should have.

Thank you!

PRESIDENT SNEDECOR: Dr. Myatt, may I ask you if you would like to make a motion now in regard to the Report of the Committee on Honorary Membership, that this subject under discussion, of the interpretation of the By-Laws be referred to the Committee on

By-Laws for report back to this House of Delegates?

Dr. Myatt: I so move.

The motion was regularly seconded.

President Snedecor: You have a motion before the House on one section of the Report of Reference Committee "D", that the report on Honorary Membership be referred for study to the Committee on Constitution and By-Laws to report back to this House. Are you ready for the question?

The motion was put to a vote and was carried.

President Snedecor: Now, Dr. Myatt, would you like to make a motion to approve the rest of your report, dealing with the other matters which were referred to you?

Dr. Londrigan: I so move.

The motion was seconded by Dr. North, was put to a vote, and was carried with one dissenting vote.

President Snedecor: In accordance with my previous procedure, I ask for approval of Dr. Myatt's report now, as we have it in two separate parts. Do I hear such a motion?

Murmurs of protest.

President Snedecor: No? All right. The Chair withdraws his suggestion.

Dr. Sprague: Will it be in order for me to make a motion pertaining to this subject?

President Snedecor: I don't think so. May I clear up the rest of these with a report from the Committee on Constitution and By-Laws?

Dr. Sprague: I should like to ask the privilege of making a motion while it is fresh in the minds of the men.

President Snedecor: I think it would not be in order now.

Dr. Hawkes: Would it be later in order?

President Snedecor: Yes.

80. Reference Committee "F"

President Snedecor: We finished with the report of Dr. Areson, and we are now taking up the Report of Reference Committee "F", by Dr. Herschel Murphy, which was as follows:

REPORT OF REFERENCE COMMITTEE "F"

Herewith follows the Report of Reference Committee "F", appointed by the President, on committee reports assigned for its consideration, namely:

The Sub-Committee on Medical Practice and the Advisory Committees on:
- Contract Practice
- Hospital Relationships
- Medical Care to Indigents
- Nursing and Nursing Education
- Workmen's Compensation
- Pharmaceutical Problems

I. The Report of the Sub-Committee on Medical Practice is approved. We wish to commend Dr. Lewis and his committee on the great amount of good work which they have done.

II. The Report of the Committee on Contract Practice recommends further study with a questionnaire to cover the salient points on Contract Practice. We think this is advisable and are in favor of the committee continuing the work which they have started. If possible, lodge practice should be one of the first things to be corrected in order to conform with the ethical standards of our profession. The report is approved.

III. The Report of the Hospital Relationships Committee is a very excellent report and one on which a great deal of work has been done. Unfortunately it is not entirely completed at the present time. We feel that the hospital survey should be carried to its completion during the coming year.

We are in accord with the thought of the committee that care of the destitute in all hospitals (except State operated institutions) is inadequately supported financially by the various communities. We feel more adequate financial support of the care of the indigents in our private hospitals by the communities is a desirable goal so that private contributions will not be expended for the care of the indigent if possible to avoid. (Dr. Murphy made one interpolation which is contained in Sect. 90c.)

We feel that the report on hospital insurance is a good one and we approve the extension of hospital insurance over the State. We feel that certain defects need to be corrected. If possible, some equitable arrangements should be made for the payment of services of the roentgenologists, pathologists and radiologists rather than under contract basis included in the hospitalization insurance.

We are in accord with the report on the control of surgical operators but we feel that younger men with proper training should be given an opportunity to operate under the supervision of the regular surgical staff. We are especially anxious that this plan shall be flexible enough and not be so exacting as to discourage the young physicians in their surgical ambitions. We feel that at some future date a report from the committee after a study of the question of open hospitals would be of value.

We recommend the adoption of this committee's report and know that Dr. Lewis and his committee has done much valuable work on the subject of hospital relationships this past year which will bear fruit in future years.

IV. The Report on Nursing and Nursing Education.—This is a very important subject and we wish to point out the fact that the period of didactic instruction prior to entering on bedside nursing duties for the under-graduate nurse is a good pro-

vision in our opinion. We feel that the plan to train nursing attendants is also excellent in order to get away from the situation in which any woman may call herself a practical nurse without any standard of training.

The adoption of this report this year is especially important in order that the nursing profession may know just where the medical profession stands on this question, and we recommend the adoption of the excellent report of this committee.

V. The Report on Medical Care of the Indigent.—We recommend the adoption of this report, and feel that when Dr. Schlichter and his committee can complete their contacts in order to set up the care of the indigent on the old E. R. A. basis that this will be of great value in the care of these people as well as of value to the medical profession. We recommend the adoption of their report.

VI. The Report on Workmen's Compensation.—We feel that this committee has done a great deal of valuable work and that this report is an excellent one. On the whole, we agree with the objectives of this committee.

We wish to suggest, however, that some plan be worked out during the transition from our present to the new plan to protect those physicians who have been doing a great deal of compensation work along with their private practice so that they will not suffer a sudden disruption of their income. Some of our committee feel that it might be well to observe the working of the New York Compensation Law for a year or two before changing our present law. However, we feel that if an employee does not wish to go to the physicians selected by his employer or the insurance carrier, that he should have free choice of his physician and that the insurance carrier should pay the medical expenses. This last idea is along the line of the thought of the Workmen's Compensation Committee.

We feel that an official Bill Adjustment Committee with legal standing would be of value to the physician and to the insurance carrier. We concur with the committee's recommendations along this line.

We are in accord with the recommended procedures relative to adjudication of cases in the Department of Labor.

We feel that the committee's suggestion that conferences be held between representatives of the Medical Society, Employers, Casualty Underwriters, Legal Profession and Department of Labor, before drawing up a new law is very necessary and that if a legislative bill can be drawn up which will be acceptable and equitable to all parties concerned, that this will be most desirable.

We feel that the whole Medical Society is greatly indebted to Dr. Fort and his committee for the very valuable work done. We recommend the adoption of their report with the above changes to be included.

VII. The Report on Pharmaceutical Problems.—We recommend that this report be accepted and we concur with Dr. Ulmer's Committee in that the center insert pages of the Journal be continued but on regular text paper and that these prescriptions be printed in a formularly booklet to be sent to the members yearly.

We feel that this is a most important subject and that this committee has done important and valuable work and are to be commended for their excellent efforts.

Respectfully submitted,

HERSCHEL MURPHY,
Chairman
J. LAWRENCE EVANS
THEODOR TEIMER
CLARENCE W. WAY
DAVID W. GREEN

80A. SUB-COMMITTEE ON MEDICAL PRACTICE

(From Sect. 40)

Dr. Murphy read the first paragraph of the report, and the paragraph I on the Report of the Sub-Committee on Medical Practice.

Upon motion made by Dr. Allman, seconded by Dr. Myatt, it was moved that this section of the Committee's report be accepted and adopted.

80 B. CONTRACT PRACTICE

(From Sect. 50)

Dr. Murphy read the section of his report dealing with the Report of the Committee on Contract Practice, paragraph II. Upon motion made by Dr. George F. Dandois, seconded by Dr. Ulmer, it was voted that this section of the report be accepted and adopted.

80 C. HOSPITAL RELATIONS

(From Sect. 51)

Dr. Murphy read the section of his report pertaining to the Report of the Hospital Relations Committee, paragraph III, with one interpolation, on page two of the report, as follows:

"When I spoke about its being inadequate a while ago, I meant this: The Committee brings out that one-third of the cost of the care of the indigent is met by the county, city, or community. We agree with the committee that, if possible, the indigent care should be more nearly met by the community."

PRESIDENT SNEDECOR: As I go rapidly through here, I call your attention to some very vital problems that are being reported. Please listen carefully and, if you object, tell me. A motion to accept and approve this is in order.

Upon motion made by Dr. Van Ness and seconded by Dr. Hawkes, it was voted that this

section of the committee's report be accepted and adopted.

80 D. Nursing and Nursing Education

(From Sect. 57)

Dr. Murphy read that section of Reference Committee "F's" report dealing with the Report on Nursing and Nursing Education, paragraph IV. Upon motion made by Dr. Farr and seconded by Dr. King, it was voted that this section of the report be accepted and approved.

80 E. Medical Care of Indigents

(From Sect. 52)

Dr. Murphy read that section of the Report of Reference Committee "F" pertaining to the Report of the Committee on Medical Care of the Indigent. Upon motion made by Dr. Pollak, seconded by Dr. McGuire, it was voted that this section of the report be accepted and adopted.

80 F. Workmen's Compensation

(From Sect. 53)

Dr. Murphy read that section of the Report of Reference Committee "F" pertaining to the Report on Workmen's Compensation, paragraph VI. Upon motion made by Dr. Butler, seconded by Dr. Yates, it was voted that this section of the report be accepted and adopted.

80 G. Pharmaceutical Problems

(From Sect. 54)

Dr. Murphy read that section of the Report of Reference Committee "F" pertaining to the Report on Pharmaceutical Problems, paragraph VII. Upon motion made by Dr. Walker, seconded by Dr. MacMillan, it was voted that this section of the report be accepted and adopted.

Upon motion made by Dr. Farr, seconded by Dr. King, it was voted to accept the Report of Reference Committee "F" as a whole, and to adopt its recommendations.

81. Honorary Membership

Dr. Sprague: Mr. President, may I——

President Snedecor: Dr. Sprague, I will listen to your motion.

Dr. Sprague: I should like to make the following motion: Pending consideration and report by the Committee on Constitution and By-Laws, it is the sense and conviction of this House of Delegates that Dr. McBride and Dr. Eagleton do not forfeit or lose any rights or privileges of Active Membership in The Medical Society of New Jersey by reason of having had bestowed upon them Honorary Membership in this Society.

Dr. Myatt: I second the motion.

The motion was put to a vote and was carried with one dissenting vote.

82. Constitution and By-Laws

President Snedecor: We will now proceed to the Report of the Committee on Constitution and By-Laws, Dr. Alexander.

Dr. Samuel Alexander: Special Reference Committee No. I, on Constitution and By-Laws, met and considered various proposed amendments to the Constitution and By-Laws and approved the proposals as submitted by the Chairman of the Committee on Constitution and By-Laws at a meeting held yesterday by the House of Delegates.

President Snedecor: You have heard the Report of the Chairman of the Committee on Constitution and By-Laws. May I ask him whether it is necessary to read those amendments, proposed amendments of the Constitution and By-Laws, at this time?

Dr. Alexander: I did what I did to expedite matters because the amendments themselves will have to be brought up under New Business and I thought then——

President Snedecor: There is no New Business at this meeting.

Dr. Alexander: This is your final meeting?

President Snedecor: Yes.

Dr. Maurice Shapiro: An amendment to the Constitution has no discussion at the present time. It is just a reading. It will have to be published in the Journal and next year will come up for second reading and discussion.

Dr. Alexander: This is the final meeting?

President Snedecor: Yes.

Dr. Alexander: Oh, well, then, I had better proceed.

President Snedecor: We are in session until we adjourn sine die.

Dr. Alexander: Dr. Snedecor and Members of the House of Delegates: Yesterday the committee submitted amendments to the Constitution that were read, and at that time I said they would not be brought up again for a vote until the next Annual Meeting. What I propose today at this meeting is a second reading of certain changes in the By-Laws, and I ask your approval of these changes, and at the same time I ask your approval of other changes to the By-Laws that have already been read twice before this House of Delegates.

President Snedecor: Should we not take these up in sections? We must.

Dr. Alexander: Yes.

Chapter VII, Section 6. Duties of Councilors. Amend by deleting that whole section.

I offer that as a motion.

Upon motion made by Dr. Shapiro, seconded by Dr. Quigley, it was voted that Chapter VII, Section 6, Duties of Councilors, be amended by deleting the whole section.

DR. MULFORD: Isn't it constitutionally correct that after the second reading of these By-Laws they have to lie over for a day before they can be voted on?

PRESIDENT SNEDECOR: Perhaps I should read the Constitution and By-Laws, Dr. Mulford, so we may be all certain.

"These By-Laws may be amended at any annual meeting of The Medical Society of New Jersey by a two-thirds vote of the members present, provided that at least fifty members are present; and, provided further, that the amendments shall have been submitted to the Committee on Constitution and By-Laws, and shall have been twice read in open meeting and laid upon the table for one day."

DR. MULFORD: After the second reading, they have to lie upon the table, after they are twice read.

PRESIDENT SNEDECOR: The Chair rules that they have been read once and laid on the table for one day, and are now up for second reading and action.

Murmurs of protest.

DR. MULFORD: Will you reread that, please?

PRESIDENT SNEDECOR: "* * * and, provided further, that the * * * " this is what you want, "amendments shall have been submitted to the Committee on Constitution and By-Laws and shall have been twice read in open meeting and laid upon the table for one day."

DR. MULFORD: That is it, Doctor. This is the second reading. Now they must lie on the table a day.

PRESIDENT SNEDECOR: I do not interpret this that they must be laid on the table after the second reading. That is one of the provisions, they must be laid on the table at least one day, but not necessarily after the second reading. This is the last session of the House of Delegates at which they can be acted upon.

DR. SHAPIRO: If you recall, on Tuesday I made that statement, that we would have to read the amendments to the By-Laws on Tuesday. You ruled otherwise.

PRESIDENT SNEDECOR: I did. I so rule now.

DR. SHAPIRO: But I believe, with Dr. Mulford, your interpretation of the Constitution and By-Laws is wrong, but in order to expedite that, I move that we suspend the By-Laws for this session.

PRESIDENT SNEDECOR: No, I will not accept that, Dr. Shapiro. I will ask the advice at this moment of the Chairman of the Committee on Constitution and By-Laws.

DR. ALEXANDER: My opinion is that Dr. Snedecor's ruling is correct. The Constitution and By-Laws calls for two readings of an amendment to the By-Laws, and then it shall be laid upon the table for one day; but there is nothing in the By-Laws which says that it must be laid on the table for twenty-four hours after the second reading. The first reading was yesterday. The second reading is today, and I would put it up for a vote by the House of Delegates at this time.

DR. MULFORD: I don't bring this up to get any discussion, nor do I want to get into argument with any delegate; but you laid that over, and it seemed to me that that specifically says that they shall be read twice and laid on the table for twenty-four hours. It is unfortunate that the twenty-four hours will bring it past the time of this meeting. According to my interpretation as an individual, and without trying to raise any discussion on it, I feel that I was right.

PRESIDENT SNEDECOR: If you wish, Dr. Mulford, the Chair will request the Committee on Constitution and By-Laws to consider that.

I am requesting at this time that the Committee on Constitution and By-Laws be continued under permission in the By-Laws, as a Special Committee to consider proposed amendments and other subjects that have been referred to it by this House of Delegates and may be referred to it by the President or the Board of Trustees in the interim to report on the first day of the next House of Delegates meeting.

Now, the Chair has set up a procedure for this meeting, with the advice of the Committee on Constitution and By-Laws, by which the By-Laws could be amended at this session, as is clearly the intent of the Constitution and By-Laws. The Chair provided for the reading of these at least one day, twenty-four hours, before action could be taken, and it is the Chair's ruling that since this is the final meeting of the House of Delegates, it is proper that action shall be taken on these amendments at this time.

Will you proceed, Dr. Alexander? Dr. Alexander, you have read Chapter VII, Section 6, of the By-Laws, Duties of Councilors—amend

by deleting the whole section. The adoption of this moved and seconded.

The motion was put to a vote and was carried.

Dr. Alexander: Amend Chapter VI, Section 3, by deleting entire present wording and substituting:

The Secretary of the Society shall have the custody of the Constitution and By-Laws of the Society and of the records of the Society and the House of Delegates, under the direction of the Board of Trustees. He shall attend all meetings of the Society and of the House of Delegates, and shall keep a record of their proceedings. He shall give notice of all general and special meetings of the House of Delegates or of the Society to the members of the said House or Society. He shall notify Honorary Members of their election.

He shall require and receive from the secretaries of the county societies a list of their representatives in the House of Delegates and the Nominating Committee, and shall publish such lists at such times and in such manner as the House of Delegates may direct.

He shall have the sole custody of the official seal of the Society, and shall affix the same to such correspondence or instruments as the By-Laws may require or the Trustees or the President may direct.

He shall conduct such formal official correspondence in the corporate name of the Society as the Trustees or the President may direct. The Board of Trustees shall make suitable provision for the detail and clerical work of the Secretary.

He shall submit annually to the House of Delegates a report of the work of his office; and shall furnish to the Board of Trustees or to the President, upon request, such information as may be necessary for the Society's business, and shall perform such other functions as are specified in these By-Laws.

He shall be entitled to necessary expenses in attending meetings or otherwise incurred in the transaction of the Society's business, as authorized by the Trustees.

I move the adoption of that amendment.

President Snedecor: You move the adoption of Chapter VI, Section 3, of the By-Laws, by deleting the entire present wording and substituting what has been read.

The motion was regularly seconded, was put to a vote, and was carried.

Dr. Alexander: Amend Chapter I, Section 2 (a) by deleting present wording and substitute:

March fifteenth in each year is the final date for closing the Official List of members. Five days before this date the treasurer of each component society shall forward to the Treasurer of this Society a complete list in duplicate of all paid-up members in good standing, with their correct addresses, at the same time remitting the assessment covering such membership. The Trustees shall arrange for the compiling and publication of the Official List from the lists so received by the Treasurer.

I offer this for adoption.

President Snedecor: Amend Chapter I, Section 2 (a) by deleting present wording and substituting what has been read.

Dr. Knowles moved, and Dr. Irwin seconded the motion, that the amendment be adopted as read. The motion was put to a vote and was carried. Dr. Irwin and Dr. Knowles requested that they be recorded at this time as moving and seconding the motion on the previous amendment (Chapter VI, Section 3).

Dr. Alexander: Chapter I, Section 2 (b). —Amend by striking out "on the first day of February" and substituting "on the fifteenth day of March".

Upon motion made by Dr. Irwin, seconded by Dr. Knowles, it was voted that the amendment to Chapter I, Section 2 (b), be adopted as read by Dr. Alexander.

Dr. Alexander: Chapter I, Section 2, subsection (d). Amend by deleting the semicolon on the sixth line and replacing a period. Also delete the remainder of this paragraph.

Dr. Knowles: I move its adoption.

Dr. Irwin: I second the motion.

President Snedecor: It is moved by Dr. Knowles, seconded by Dr. Irwin, that Chapter I, Section 2 (d), page 12, be amended after the words "component society" eliminate the semicolon and make it a period, and delete the rest of the paragraph.

The motion was put to a vote and was carried.

Dr. Alexander: Now, the following amendments, which are recommended, have been read twice before the House of Delegates. Do you want me to read them again in toto or by title.

Several Members: By title.

President Snedecor: I will accept a motion by Dr. Irwin, seconded by Dr. Knowles, that these following proposed amendments submitted by Dr. Alexander, having been read twice, and twenty-four hours having intervened between those two readings, that they be read by title at this time and voted upon.

The motion wa sput to a vote and was carried.

Dr. Alexander: Chapter IX, Section 2

(a)— General Fund, substituting the date 15 of March in place of February 1, page 34.

Upon motion made by Dr. Knowles, seconded by Dr. Irwin, it was voted that the proposed amendment be adopted.

DR. ALEXANDER: Chapter I, Section 4—Registration at Annual Meetings. Amend by striking out the words "in the registration book" and substitute therefor "on an official registration card which shall be duly presented at the registration desk."

Upon motion made by Dr. Irwin, seconded by Dr. Knowles, it was voted that the proposed amendment be adopted.

DR. ALEXANDER: Chapter X, Section 3—Qualifications of Members. Amend by adding the following subsection (a): "It is hereby required that all physicians applying for membership in Component Medical Societies, shall present to the Committee on Membership or to the Secretary of the Component Society, a license to practice medicine in this State, granted by the New Jersey State Board of Medical Examiners."

Dr. Knowles moved, and Dr. Irwin seconded the motion, that the proposed amendment be adopted.

DR. EAGLETON: May I ask whether this means that to become a member of a County Society you have to show your certificate?

DR. ALEXANDER: Present evidence, "a license to practice medicine in this State Board of Medical Examiners."

DR. EAGLETON: First of all, I don't approve of this way of passing very important things. I know about this. I lived it. In Essex County, when we had a scientific organization, and it was only scientific, we used to require exactly what you are asking here, that a man should go with his diploma and with his certificate, before the Credentials Committee, and show them that he was eligible to become a member. Some of the best men in Essex County just simply refused to do it. They were pig-headed. They said, "The State has given me a license. Why should I inconvenience myself?" Of course, Essex County at that time, as a body that was doing something for the doctors, was of no value, so we abolished that in Essex County and we put it on the Credentials Committee; they were the ones to see that this man who made application was a licensed physician. We put the responsibility back on the county, not on the man, with the result that we got in many men who otherwise would not have come in.

To adopt a rule like this is to go back to an old condition that acted badly in Essex County, and I think it is a mistake to have such a provision. There should be in that that evidence be submitted, but it shouldn't say "by the applicant". It should put it on the body of the County Society. They should be the ones to go to the city hall, or wherever it is necessary to go, and find out whether these men are registered.

DR. SHAPIRO: For once I can agree with Dr. Eagleton, and I therefore move that this matter be referred back to the Committee on By-Laws, to be reported upon next year.

PRESIDENT SNEDECOR: Dr. Shapiro, there is a motion before the House.

DR. KNOWLES: I withdraw my motion.

DR. IRWIN: I withdraw my second.

DR. DARLINGTON: I will second Dr. Shapiro's motion.

Dr. Shapiro's motion was put to a vote and was carried.

DR. ALEXANDER: The Standing Committees at the present time are: Nominating Committee, Committee on Finance, Scientific Work, Program and Arrangement, Publication, Honorary Member, Welfare, Hospital, Medical Education, Committee on Medical Defense, Committee on Insurance, and such other Committees as the House of Delegates shall determine.

The recommendations are as follows, that the Standing Committees shall be, amending Chapter VIII, Section 2—the recommendations are as follows:

The Standing Committees shall be:

Nominating Committee
Committee on Finance
Committee on Annual Meeting
Publication
Honorary Membership
Welfare
Post-Graduate Education
Medical Defense and Insurance
Woman's Auxiliary

and such other committees as the House of Delegates shall determine.

I might say that that has been read twice before the delegates and I will read it by caption unless you desire otherwise.

DR. SHAPIRO: I move its adoption.

DR. ALLMAN: I second the motion.

The motion was put to a vote and was carried.

DR. ALEXANDER: Chapter VIII, Section 6—Scientific Committee. Amend by striking out the entire section and substituting the following—and that is brought about by reason of the change in set-up. That has been read twice before this group. (See p. 51 for context.)

Upon motion made by Dr. Irwin and seconded by Dr. Knowles, it was voted that the amendment be adopted.

Dr. Alexander: Chapter VIII, Section 7—Program and Arrangements Committee. Delete Section 7—for the same purpose. That has been read twice.

Upon motion made by Dr. Knowles and seconded by Dr. Irwin, it was voted that the amendment be adopted.

President Snedecor: If you object to these, please stand up and you will have the floor.

Dr. Alexander: Chapter VIII, Section 8. Amend to read Section 7.

Dr. Shapiro: All of these are just an advance in number. They really don't mean anything. Suppose the numbers are read off and grouped, and we pass the motion to advance them one number.

President Snedecor: The Chair is sorry, but they must be amended by sections. I will repeat it as rapidly as possible.

Dr. Irwin moved, and Dr. Knowles seconded the motion, that the proposed amendment be adopted. The motion was put to a vote and was carried.

Dr. Alexander: Chapter VIII, Section 9. Amend to read Section 8.

Upon motion made by Dr. Knowles, seconded by Dr. Irwin, it was voted that the proposed amendment be adopted.

Dr. Alexander: Chapter VIII, Section 10. Amend to read Section 9.

Upon motion made by Dr. Irwin, seconded by Dr. Knowles, it was voted that the proposed amendment be adopted.

Dr. Alexander: Chapter VIII, Section 10. —Welfare Committee. That has been read twice and is up for final adoption; page 30, beginning on line 8, and so forth.

Upon motion made by Dr. Knowles, seconded by Dr. Irwin, it was voted that the proposed amendment be adopted.

Dr. Alexander: Chapter VIII, Section 11. Amend Section 11 to read Section 10.

Upon motion made by Dr. Irwin, seconded by Dr. Knowles, it was voted that the proposed amendment be adopted.

Dr. Alexander: Chapter VIII, Section 10. Amendment as submitted, be approved. Moved by Dr. Knowles, seconded by Dr. Irwin, adopted.

Dr. Alexander: Chapter VIII, Section 12. Amend Section 12 to read Section 11.

Upon motion made by Dr. Knowles, seconded by Dr. Irwin, it was voted that the proposed amendment be adopted.

Dr. Alexander: Chapter VIII, Section 11. Amendment as submitted. Moved by Dr. Knowles, seconded by Dr. Irwin. Adopted.

Dr. Alexander: Chapter VIII, Section 13. Amend Section 13 to read Section 12.

Upon motion made by Dr. Irwin, seconded by Dr. Knowles, it was voted that the proposed amendment be adopted.

Dr. Alexander: Chapter VIII, Section 14. Amend Section 14 to read Section 12.

Upon motion made by Dr. Knowles, seconded by Dr. Irwin, it was voted that the proposed amendment be adopted.

Dr. Alexander: Section 15. Amend Section 15 to read Section 13.

Upon motion made by Dr. Irwin, seconded by Dr. Knowles, it was voted that the proposed amendment be adopted.

Dr. Alexander: Section 16. Amend Section 16 to read Section 14.

Upon motion made by Dr. Knowles, seconded by Dr. Irwin, it was voted that the proposed amendment be adopted.

Dr. Alexander: Section 17. Amend Section 17 to read Section 15.

Upon motion made by Dr. Irwin, seconded by Dr. Knowles, it was voted that the proposed amendment be adopted.

Dr. Alexander: Section 18. Amend Section 18 to read Section 16.

Upon motion made by Dr. Knowles, seconded by Dr. Irwin, it was voted that the proposed amendment be adopted.

Dr. Alexander: That is all so far as the Committee on Constitution and By-Laws has to offer.

Mr. President, may I offer the following resolution that I presented yesterday? I will read it, just a resolution.

"Associate members of component societies shall be physicians who may be elected to active membership after a period of probation. All others now called Associate Members shall be termed Courtesy Members."

President Snedecor: This resolution was referred yesterday to the Committee on Constitution and By-Laws for report today. You have heard the Report of the Committee. Do I hear a motion?

Dr. North: I move the adoption of the resolution as read.

The motion was seconded by Dr. Farr, was put to a vote, and was carried.

Dr. Shapiro: Before Dr. Alexander leaves the platform, I believe there is a By-Law that was read yesterday, presented by Hudson County on the Committe on Finance. You have a copy and the Secretary was given a copy.

Dr. Alexander: Mr. President, Dr. Sha-

piro presented to the Committee yesterday two amendments to the By-Laws. At yesterday's meeting he read these amendments, and I would suggest, if I may, Mr. President, that if Dr. Shapiro wants to present the amendment today, he can do that and get a vote.

President Snedecor: May I ask the action of the Committee in reference to that?

Dr. Alexander: The Committee did not approve or disapprove of them.

Dr. Shapiro: It should have been presented for second reading.

President Snedecor: I will recognize you if you wish to read it.

Dr. Shapiro: I don't wish to read it, but I think once it has been presented to the Secretary and the Committee, it automatically has to be read. I don't have to get up to again read it.

President Snedecor: The point of a reference committee, I would rule, is to cover these things as referred to them—it is in the Constitution and By-Laws—and report back such as they approve. If you wish to have it read—

Dr. Shapiro: I withdraw it for the present.

Dr. Alexander: There seems to be some difference of opinion on the way to amend the By-Laws, and just to clarify the situation, I think it should be read once more. The point I am trying to make is this, that any Member of the House of Delegates can present an amendment to the House of Delegates if he so desires, the only requisite being that it be submitted to the Committee on Constitution and By-Laws, that it be read twice, and laid on the table twenty-four hours before it can be presented to the House of Delegates for a vote.

83. Resolutions and Memorials

President Snedecor: All right. Thank you, Dr. Alexander. We will go on and hear a report from Special Reference Committee No. II, on Resolutions and Memorials, Dr. Watson B. Morris, Chairman.

Dr. Morris read the Report on Special Reference Committee No. II on Resolutions and Memorials as follows:—

REPORT OF COMMITTEE ON RESOLUTIONS AND MEMORIALS

The Committee on Resolutions and Memorials beg to submit the following report:—

(From Sect. 65)

1. Resolution that associate members of the component societies shall be physicians who may be elected to active membership after a period of probation. All others now called associate members shall be termed Courtesy Members, is approved.

(From Sect. 12)

2. Resolution that the delegates of the Hudson County Society to the next State Convention be now instructed to make diligent inquiry of the President, Executive Officer, and the Secretary of the Medical Society of New Jersey, with a view of effecting some economies in the management of the State Society which would reflect themselves in a reduction of the State Society assessment of $13.00.

This does not meet with the approval of the committee, as any reduction in dues would make it imperative to curtail the present and contemplated program of the Society.

Watson B. Morris
J. J. Mann
Frederic J. Quigley

Upon motion made by Dr. Van Ness, seconded by Dr. Allman, it was voted to accept and adopt the report.

84. Credentials

President Snedecor: We are now ready to hear the Report of Special Reference Committee No. III, on Credentials, Dr. H. Roy Van Ness, Chairman.

Dr. Van Ness read the Report of Special Reference Committee No. III, on Credentials, as follows:—

Special Reference Committee on Credentials wishes to report that the Total registration is as follows:

Counties	Delegates	Members	Woman's Aux.	Guests
Atlantic	8	86	51	139
Bergen	14	10	10	16
Burlington	5	16	13	1
Camden	11	28	19	10
Cape May	4	7		1
Cumberland	4	15		5
Essex	52	54	28	31
Gloucester	5	11	9	10
Hudson	27	28	11	22
Hunterdon	2	2		5
Mercer	13	29	13	12
Middlesex	5	20	9	8
Monmouth	9	40	15	17
Ocean	2	10	6	4
Passaic	13	18	10	7
Salem	1	6		3
Somerset	3	14	7	4
Sussex	1	1		
Union	19	28	14	11
Warren	2	6	4	2
Morris	6	13		9
	206	432	219	317

Visiting Doctors	58
Exhibits	76
Delegates	206
Members	432
Woman's Auxiliary	219
Guests	317
Total Registration	1308

All Delegates were legally registered.

H. ROY VAN NESS, *Chairman*
J. B. MORRISON, *Sec.*
E. J. MARSH, *Treas.*

Upon motion made by Dr. MacMillan, seconded by Dr. Walker, it was voted that the report be accepted and approved.

85. LEGALITY OF ELECTION OF COUNCILORS
(From Sect. 69)

PRESIDENT SNEDECOR: We now come to the Report of the Special Committee, a reference committee, appointed by the Chair yesterday to consider the legality of the election of Dr. William J. Sweeney as Councilor to the Medical Society in 1935, and report back to us today. Dr. D. Leo. Haggerty is the Chairman.

DR. D. LEO HAGGERTY: The Special Reference Committee appointed by President Snedecor to consider the resolution presented by the Hudson County Medical Society declaring the election of Dr. William J. Sweeney illegal because he was not a Delegate at the time of his election as District Councilor, met in the Tower Room this morning. The Committe inquired diligently into all the evidence presented, with the following conclusion:

It is unanimously agreed by your Committee that the Official Records of 1935 show that Dr. William J. Sweeney was not an elected Delegate from Hudson County in 1935, nor did he have necessary credentials or sign the Official Registration Book of 1935, which is necessary, according to Article VII, page8, of the Constitution, and Section IV and V, Section (a) of By-Laws; therefore, it is our duty to report that Dr. Sweeney was not eligible to be elected District Councilor, as he was not an elected official delegate.

Respectfully submitted,

D. LEO HAGGERTY
E. Z. HAWKES
SAMUEL B. ENGLISH
E. R. MULFORD.

This report in manuscript form is marked No. 28.

SECRETARY MORRISON: Before that is put, I wish you would strike out the word "official". Right at the end it should be "elected delegate", and not "elected official delegate".

The change was agreed to and made by Dr. Haggerty.

PRESIDENT SNEDECOR: That is right. Do I hear a motion for the acceptance and approval of this report?

DR. FARR: I so move.

DR. SPRAGUE: I second the motion.

The motion was put to a vote and was carried.

PRESIDENT SNEDECOR: Gentlemen, are there any other special committees to report?

I appointed a Committee on Miscellaneous Business, a reference Committee, but I understand they had no reports or resolutions referred to them.

We will now go on and consider the next item, which is motions under unfinished business.

86. ELECTION OF COUNCILOR

DR. JAMES F. NORTON: In view of the action of the House of Delegates on the Report of the Special Committees, I should like to call attention to the Chair and the House, that there now exists a vacancy in the office of the Judicial Council from the Second District of this Society, and I ask that this Society proceed to elect a Councilor for the Second Judicial District to fill the unexpired term of Dr. Sweeney.

The motion was seconded by Dr. Shapiro.

PRESIDENT SNEDECOR: That should be two motions I believe. We have accepted the report of the Special Committee. I will accept a motion first to declare that there is a vacancy, and then another motion.

DR. NORTON: It is understood that that is done.

DR. QUIGLEY: I second the motion.

The motion was put to a vote and was carried.

PRESIDENT SNEDECOR: The Chair will now entertain a motion that an election be held at this time to fill the vacancy found to be existing in the Second Judicial District, for the unexpired term of Dr. Sweeney.

Murmurs of protest.

PRESIDENT SNEDECOR: Excuse me. The Chair would rule that it must be for one year.

DR. NORTON: I don't know.

PRESIDENT SNEDECOR: That makes it the unexpired term.

SECRETARY MORRISON: The fact that Dr. Sweeney was illegally elected to the Judicial Council doesn't have any bearing whatsoever

upon the actions of the Judicial Council. If you had a Senator from your County elected to represent you in Trenton, and he was elected illegally, as Hunt was, in South Jersey, he will sit until his election is declared illegal, so we must elect a Councilor to fill out this unexpired term.

PRESIDENT SNEDECOR: Do I hear a second to Dr. Norton's motion?

DR. QUIGLEY: I second it.

PRESIDENT SNEDECOR: It has been regularly moved that an election be held to fill the vacancy in the Second Judicial District, and the motion has been seconded.

DR. SPRAGUE: Until the next regular election.

PRESIDENT SNEDECOR: Yes. Thank you. Is there discussion? Are you ready for the question?

The motion was put to a vote and was carried.

PRESIDENT SNEDECOR: We will now proceed to the election of Council from the Second Judicial District.

DR. NORTON: I should like, since this vacancy exists in the Second Judicial District, and since Hudson County is one of the Component Societies in the Second Judicial District, to present the name of Dr. Vincent P. Butler, of Jersey City, to hold office until the next regular election.

DR. ALEXANDER: Coming from Bergen County, a component part of this Judicial District, it gives me a great deal of pleasure to second that nomination. (Applause)

PRESIDENT SNEDECOR: You have heard the nomination of Dr. Vincent P. Butler, of Jersey City, for this office, seconded by Dr. Alexander. Are there any other nominations?

DR. NORTON: May I have one word before you put it to a vote? We, of Hudson, are now overwhelmed by the gesture of good feeling from the rest of the House.

PRESIDENT SNEDECOR: May I ask once more, are there any further nominations?

DR. THOMAS K. LEWIS: I move that the nominations be closed and that the Secretary be instructed to cast one ballot for the election of Dr. Vincent P. Butler, of Jersey City.

The motion was seconded by Dr. Hilton S. Read, was put to a vote, and was carried. The Secretary announced that the ballot had been cast, and President Snedecor declared Dr. Butler elected Judicial Councilor from the Second District. Dr. Butler arose amid applause.

87. Introduction of New Officers

PRESIDENT SNEDECOR: Perhaps at this time it would be fitting to introduce one or two more of our new officers. We need a moment's variation as we are getting toward the close. I should like to introduce a man just elected as Second Vice-President of the State Society, Dr. Watson B. Morris. (Applause.) We are very glad you are elected, Dr. Morris, and we wish to acknowledge that and recognize you.

We have also the election of a new Secretary whom we wish to recognize, Dr. Alfred Stahl. (Applause.)

SECRETARY MORRISON: In retiring from the position of your Secretary, I welcome the election of Dr. Stahl, and I trust that you will extend to him the same degree of courtesy, cooperation, and warm friendship that you have always extended to me. (Applause.)

PRESIDENT SNEDECOR: There are one or two further matters to come before this meeting, such as selecting a place for the meeting next year.

88. Special Legislation for Licenses to Practice

DR. B. S. POLLAK: Mr. President, within the last twenty-four or thirty-six hours a bill has been introduced, known as Assembly 526. To be brief, it would give some individual a special privilege to be recognized by the State Board of Medical Examiners; and while our committee could handle this problem, yet the Delegates being in session, I should like to have the House of Delegates authorize our committee so that we may go to the Legislature and say that the House of Delegates approved this legislation, because last year we had a similar problem before us and we——

PRESIDENT SNEDECORS You said "approved". You mean "disapproved", do you not?

DR. POLLAK: Approved our action, I mean.

PRESIDENT SNEDECOR: We disapprove of this proposed legislation.

DR. POLLAK: Last year we had a similar bill, and Senator Stout, who was the advocate of this gentleman practicing in Passaic County, felt very much aggrieved at my action in asking the Hudson County people to vote against it, which they did; and he considered that a personal act of mine rather than an act by the House of Delegates.

Now, I should like to have the House disapprove of this Assembly 526, so that we may say that it has the disapproval, this bill has the disapproval, of The Medical Society of New Jersey.

PRESIDENT SNEDECOR: Dr. Pollak, is that in the Report of the Committee on Legislation?

DR. POLLAK: I haven't had opportunity to put it in.

President Snedecor: It requires unanimous consent.

Dr. Pollak: Dr. McGuire will read it, if you like.

Dr. McGuire: I will give you the substance of the bill.

President Snedecor: Before you do that, may I ask whether the House wishes to consider this motion. It must be by unanimous consent.

General assent.

President Snedecor: It is so ordered.

88 A. Licenses by Reciprocity

Dr. McGuire: This bill was just sent down to me today and I have called Dr. Pollak's attention to it, and the provisions in this bill provide that the State Board of Medical Examiners exercise their discretionary power in granting a license obtained by examination in those states that have substantially the same requirements as we have. That was the condition of the statute prior to the amendment of the act in 1935; in other words, we had discretionary powers to accept by reciprocity applicants to be licensed who could not meet the requirements for examination.

This bill, if passed, will put us back in the same condition as we were in then. At the present time a man, to gain a license by reciprocity, must have the same requirements as for examination. If this bill were to pass, again we would go back to the situation where we will have to exercise discretionary power, and you know what that means. If we are given discretionary power, all kinds of influence is brought to bear on us to exercise that. We did not wish it, and when we had an opportunity to amend the act covering it, so we did, and I feel that this House of Delegates should go on record as opposing this bill.

President Snedecor: Gentlemen, you have heard Dr. McGuire's explanation, and, Dr. Pollak, was that a motion?

Dr. Pollak: Yes.

President Snedecor: Dr. Pollak's motion is that we disapprove of this Assembly Bill No. 526.

The motion was regularly seconded, was put to a vote, and was carried.

89. Tri-State Directory of Physicians

President Snedecor: Is there any other Unfinished Business?

Dr. Herschel Murphy: I am one quite sure whether this is Unfinished Business. I arise more for information than to defend it as Unfinished Business.

We discussed something about the New York, New Jersey, and Connecticut Register. What happened on that, and what is necessary in order to have a copy for the New Jersey members?

President Snedecor: To the best of my knowledge, no action has been taken by this House of Delegates in respect to that directory.

Dr. Murphy: It was considered in this session.

Secretary Morrison: By the Board of Trustees, and no action taken till next year.

President Snedecor: I will ask Dr. Quigley if he wishes to say something.

Dr. Quigley: To clear this, I mentioned yesterday, or rather on Tuesday, that the Board of Trustees had received this proposition from the New York State Society, namely, that this Directory of New York, New Jersey, and Connecticut would be made available to the membership of The Medical Society of New Jersey, provided there was a per capita tax of $1 paid. This directory is furnished to every member of the New York State Society.

I further stated that the proposition was merely presented to the House of Delegates with no recommendation, merely for its consideration, with no recommendation one way or the other so far as the Board of Trustees was concerned.

President Snedecor: Since it has been presented to the House of Delegates, but no previous action has been taken, I would rule it out of order at this present time, unless you wish unanimous consent to do something about it. It was merely presented.

Dr. Murphy: Is that New Business or Old Business?

President Snedecor: It is New Business.

Dr. Murphy: Is it Unfinished Business.

President Snedecor: I will rule it is New Business, any motion to approve that now.

Dr. Murphy: I don't believe we would get unanimous consent, because it costs a dollar, so I will sit down. (Laughter.)

President Snedecor: Is there any further unfinished business?

90. Meeting Place in 1938

Dr. David B. Allman: At the last meeting of the Atlantic County Medical Society, I was delegated to express the unanimous invitatio nof the society to the State Society to meet here for their 172nd convention, and I move, therefore, that this Society meet in Atlantic City next year.

The motion was seconded by several members.

President Snedecor: I will say one thing at the request of the incoming President, Dr. Herrman. He believes that it is the sentiment of the Society to come back here next year, and he wishes to go along fully with the wishes of the Society. He does believe, however, that careful consideration of the possibilities of other meeting places should be taken up by a special committee which he would like to be empowered to appoint, to report back at the next meeting.

Now the motion before you is on the approval of Atlantic City as the meeting place for the 172d Annual Meeting.

Secretary Morrison: Wouldn't that have to be considered by our Arrangements Committee? That is what the committee is for—not a special committee.

President Snedecor: We will refer it to the Committee on Program and Arrangements tentatively, but Dr. Herrman wanted rather an impartial committee from around the State. The Committee on Program and Arrangements is essentially an Atlantic City committee at the moment.

The motion to approve of Atlantic City as the meeting place for the 172d Annual Meeting was put to a vote, and was carried.

President Snedecor: Is there any other Unfinished Business?

If you will bear with the Chair for one minute, we will be through.

91. Thanks and Adjournment

We wish to extend thanks for coöperation given by so many individual members and Chairmen of committees, and so it is with very mixed emotions that we really do expire. We should like particularly to thank the Chairman of the Board of Trustees, who goes out of office this year, for his inspiration and his help during many years of work we have had with The Medical Society of New Jersey. We think Dr. Frederic J. Quigley has contributed greatly to the success of the Medical Society in the past few years.

There being no further business to come before us, a motion to adjourn is in order.

Upon motion regularly made and seconded, it was voted to adjourn sine die. The meeting adjourned at 3:15 o'clock.

(Signed)	(Signed)
Spencer T. Snedecor	J. B. Morrison
President	*Secretary*

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PART TWO

SCIENTIFIC FEATURES OF THE ANNUAL MEETING

The scientific features of the Annual Meeting were conducted along six lines:

1. General meetings in which the entire Society participated.
2. Meetings of four sections devoted to specialties of practice.
3. A scientific exhibit.
4. An exhibit in Medical History.
5. Technical exhibits.
6. General publicity of the Annual Meeting.

The importance of the scientific features of the Annual Meeting of The Medical Society of New Jersey is far greater than is indicated by the relatively few pages devoted to scientific features in the annual Transactions. The programs of the scientific departments are printed here in detail for the sake of preserving their record in available form; but the papers and discussions will appear in the department of "Original Articles" in each issue of The Journal; and in the aggregate, the number of pages devoted to them during the year will be at least four times as great as those devoted to the "Transactions" of the House of Delegates.

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1. GENERAL SCIENTIFIC SESSIONS

Three General Scientific Sessions were held during the Annual Meeting of 1937.

A. On the evening of Tuesday, April 27th, a General Public Health Session was addressed by three speakers of nation-wide reputation, as follows:

Charles Gordon Heyd, M.D., President of the American Medical Association and noted New York Surgeon and leader in medical thought. Subject: "Society and Organized Medicine".

Thomas Parran, M.D., Surgeon General, United States Public Health Service; President, American Public Health Association; former Commissioner of Health, New York State. Subject: "What Can the Private Physician Do to Aid in the Control of Syphilis?"

Howard W. Haggard, M.D., Yale University, author of "Devils, Drugs, and Doctors" and other books of interest both to the profession and to the public. A true medical philosopher. Subject: "The Social Aspects of Medicine".

These addresses were published in the June Journal, pages 373-383.

B. A General Scientific Session on the afternoon of Tuesday, April 27th, 1937, with the following program:

1. Indications for Splenectomy (Lantern)
   William P. Thompson, M.D., New York City, Associate in Medicine, College of Physicians and Surgeons; Assistant Physician, Presbyterian Hospital.

2. Results of Splenectomy in Some One Hundred Cases of Various Types of Splenopathy (Lantern)
   Allen O. Whipple, M.D., New York City, Valentine Mott Professor of Surgery, Columbia University.

3. Medical Aspects of Coma (Lantern)
   William Hall Lewis, Jr., M.D., New York City, Assistant Clinical Professor of Medicine, New York University College of Medicine; Assistant Attending Physician, Bellevue Hospital

4. The Surgical Management of Coma
   J. Arthur MacLean, M.D., New York City, Surgical Service, Psychiatric Division, Bellevue Hospital.

5. Selection of Treatment for the Tuberculous Patient.
   J. Burns Amberson, Jr., M.D., New York City, Professor of Clinical Medicine, College of Physicians and Surgeons, Columbia University, and New York University College of Medicine.

6. Management of Tuberculous Empyema
   Adrian V. S. Lambert, M.D., New York City, Professor of Clinical Surgery, College of Physicians and Surgeons, Columbia University

7. Electrosurgical Aseptic Intestinal Anastomosis (Lantern)
   Victor Carabba, M.D., New York City, Assistant Clinical Professor of Surgery, New York University College of Medicine; Assistant Visiting Surgeon, Bellevue Hospital.

C. A General Scientific Session on the morning of Thursday, April 29th, 1937, with the following program:

1. The Treatment of Pituitary and Ovarian Disfunction
   Rita S. Finkler, M.D., Newark, Adjunct Gyne-

cologist, Endocrine Clinic, Newark Beth Israel Hospital.
Milton Friedman, M.D., Newark, Associate Roentgenologist, Radiation Therapy, Newark Beth Israel Hospital.

2. Again,—Maternal Mortality Problems
Frederick C. Holden, M.D., New York City, Professor Emeritus of Obstetrics and Gynecology, New York University College of Medicine

3. Failures After Gastro-jejunostomy—A Clinical and Experimental Study (Lantern)
W. Howard Barber, M.D., New York City, Clinical Professor of Surgery, New York University College of Medicine.
Anthony Bogatko, M.D., New York City, Assistant Clinical Professor of Surgery, New York University College of Medicine.

4. Oxygen Therapy by Oro-pharyngeal Insufflation (Motion pictures)
E. A. Rovenstine, M.D., New York City, Assistant Professor of Surgery (Anesthesia), New York University College of Medicine; Director of Anesthesia, Bellevue Hospital.

5. Management of Ureteral Calculus
Stanley R. Woodruff, M.D., Jersey City, Urologist, Bayonne Hospital and Christ Hospital, Jersey City; Assistant Professor of Urology, New York Post-Graduate Medical, and University of Columbia Hospital, New York City.

6. Congenital Abnormalities of the Lower Uro-Genital Tract
Hugh Young, Baltimore, Brady Urological Institute, The Johns Hopkins Hospital, Baltimore, Md.

2. MEETINGS OF THE FOUR SCIENTIFIC SECTIONS

A. SECTION ON EYE, EAR, NOSE, AND THROAT

CHARLES F. ADAMS, M.D., *Chairman,* Trenton (Died December 14, 1936)
D. M. YAZUJIAN, *Secretary,* Trenton

FIRST SESSION

The first meeting of the Section on Eye, Ear, Nose, and Throat was held on Wednesday, April 28th, 1937, at 9:30 a. m. The meeting was opened by Dr. D. M. Yazujian, who suggested that a new Chairman be appointed for the duration of the meeting to fill the vacancy created by the death of Dr. Charles F. Adams, Chairman of the Section, who died on December 14, 1936. It was unanimously agreed that since Dr. Yazujian had carried on all the work of developing the program of the Section, he should be Chairman of the meetings. Dr. H. L. Harley was appointed temporary Secretary.

Dr. Yazujian spoke of his associations with Dr. Adams and expressed the loss felt in the passing of a man so active and so beloved as Dr. Adams. The members stood for a moment in silent homage to his memory.

The first paper of the morning was on "Nose and Throat Infections as a Cause of Ocular Disease", by Dr. E. Clarence Kern of Montclair, and was discussed by Drs. J. A. Fisher, Sherwin L. Haseltine, E. LeRoy Wood, C. L. Littwin, and Louis Lehrfeld.

The second paper was read by Dr. Louis Lehrfeld, of Philadelphia, and was on "Recent Advances in Vernal Conjunctivitis". Dr. Lehrfeld illustrated the paper with colored motion pictures. Discussion by Drs. G. P. Meyer and C. L. Littwin.

"Uveal Tuberculosis", by Dr. George P. Meyer, of Camden, was the third paper, and discussion was omitted because of press of time.

Dr. Sherwin L. Haseltine, of Elizabeth, read the fourth paper of the morning on "Suprarenal Gland in the Treatment of Glaucoma, Progressive Myopia, and Some of the Allergic Conditions". Discussion on this paper was omitted because of press of time.

The last paper of the morning was read by Dr. W. G. Hayden, of Toms River, on "Do We Operate Our Refractive Departments Gainfully?" Discussion was lead by Dr. J. W. Hurff.

The hasty discussion led to the passing of a motion offered by Dr. Charles Littwin that:

"A committee be appointed to discuss the subject so pointedly made in Dr. Hayden's paper." The motion was seconded and carried.

The Chairman appointed the following members to act as the committee: Drs. W. G. Hayden, E. J. Marsh, E. S. Sherman, J. W. Hurff, D. F. Reiner, J. A. Fisher, and C. H. Schlichter.

The Secretary offered a motion, suggested

by Dr. Marsh (who was busy in committee), that:

"The Section requests the Public Health Committee of the State Society to take up the problem of the prevalence of glaucoma with a view to the education of the public on the seriousness and insidiousness of this disease as a cause of blindness."

The motion was seconded and carried.

There were thirty-two in attendance at the session.

HARVEY L. HARLEY,
Secretary pro tem.

SECOND SESSION

The second meeting of the Section on the *Eye, Ear, Nose, and Throat* was called to order at 2:30 p. m. on Thursday, April 29th, by Acting Chairman, Dr. Yazujian.

The first speaker of the afternoon was Dr. Alfred M. Mamlet, of Newark, who gave a paper on "Plastic Repair an Aid in Therapeutic Nasal Surgery". Dr. Mamlet exhibited masks to illustrate the cases he presented in his paper. Discussion was opened by Dr. Kurt Engelmann, of Berlin and New York. Dr. Edgar P. Cardwell, of Newark; Dr. Edward A. Atwood, of Paterson, and Dr. H. M. Glasston, of Linden, also discussed the paper. The discussion was closed by Dr. Mamlet.

The second paper on the program was presented by Dr. Edward A. Atwood, of Paterson, on "Malignant Tumors of the Upper Air Passages". This paper aroused an interesting discussion which was led by Dr. Henry B. Orton, of Newark, and followed by Dr. Alfred M. Mamlet, of Newark; Dr. Norman W. Burrit, of Summit, and Dr. Edgar P. Cardwell, of Newark. Dr. Atwood closed the discussion.

It was suggested that because of the marked interest in the subject of Dr. Atwood's paper, a symposium should be arranged for presentation at one of the General Scientific Sessions of next year's Annual Meeting.

The third paper listed in the program was not presented. The Chairman explained that at the time the program was made up, the afternoon session was listed as beginning at 3:30 and therefore allowed for the reading and discussion of only two papers. At a late date before the meeting however, the afternoon sessions was moved up to 2:30, thus allowing time for another paper. At the Chairman's request, Dr. Norman W. Burritt, of Summit, consented at that late date to present a paper on "The Ethmo-Sphenoidal Sinus Operation as an Office Procedure", but was unable to get his data together, and found no time for its adequate preparation.

Dr. Yazujian read a report from Dr. Elias J. Marsh relating to the Kipp Memorial Fund, which stated that the fund had only $30 without any new additions or disbursements.

It was decided to help keep the fund alive in the future years.

It was felt that the entire Section meeting should be held in one day, as it would insure a large and complete attendance, and would give those men attending the State meeting for only one day, an opportunity to hear all the papers on the program. Dr. Yazujian explained that the Program Committee not having been able to allow one whole day to the Section this year, the papers had to be distributed over two separate half days.

NEW OFFICERS

The Nominating Committee, composed of Dr. James A. Fisher and Dr. C. Coulter Charlton, nominated Dr. Oram Kline, of Camden, for Chairman, and Dr. James S. Shipman, of Camden, for Secretary, for the ensuing year. The candidates were unanimously elected.

There were about twenty-five in attendance.

D. M. YAZUJIAN, *Chairman.*

B. SECTION ON PEDIATRICS

CHESTER R. BROWN, *Chairman,* Arlington
KENNETH BLANCHARD, *Secretary,* East Orange

FIRST SESSION

Two sessions of the Pediatric Section were held. The first session was held on the morning of Wednesday, April 28th, 1937, with the following program:

Panel Discussion on Contagious Diseases
Director of Panel
Philip M. Stimson, M.D., New York City
Diagnoses
H. Orlando Bell, M.D., Lyndhurst
Treatment and Prevention
Maurice L. Ripps, M.D., Elizabeth
Department of Public Health in Contagious Diseases
Joseph W. Gardam, M.D., Newark
Institutional Care of Contagious Diseases
Ellis L. Smith, M.D., Belleville

The program of this session consisted of a conversational discussion in which the speakers sat together upon the platform and took part in discussions with a dignified informality which characterizes a small group of practitioners when they happen to meet, each one contributing his ideas spontaneously.

This is the first time that the panel type of discussion has been used in a meeting of The Medical Society of New Jersey. It proved to be very successful and of much interest to the audience. The largest attendance at any one time during this session was eighty-eight members.

SECOND SESSION

The second session of the Pediatric Section was held on the afternoon of Thursday, April 29th, 1937, with the following program:

1. The Relation of Orthodontia to Pediatrics
   Ralph Waldron, D.D.S., Newark
   Discussor: Fletcher I. Krauss, M.D., Chatham
2. Is School Medical Work a Part of Pediatrics?
   Harry B. Silver, M.D., Newark
   Discussor: Joseph Shapiro, M.D., Union City
3. Conduct Disorders in Childhood
   Leslie E. Hohman, M.D., Baltimore, Md.
   Discussor: James S. Plant, M.D., Newark
4. The New Born—"An Obstetric or Pediatric Responsibility?"
   Robert Wright, M.D., East Orange
   Discussors: Frederick W. Lathrop, M.D., Plainfield; Robert A. MacKenzie, M.D., Asbury Park

The New Jersey Association of School Physicians met with this Section, and the meeting room was filled to its capacity.

Officers of the Pediatric Section for the year 1937-1938 were chosen as follows:

Chairman, Kenneth Blanchard, 25 South Munn Avenue, East Orange
Secretary, Irving Okin, 158 Passaic Avenue, Passaic

KENNETH BLANCHARD, M.D.,
Secretary.

ACADEMY OF PEDIATRICS

The New Jersey Fellows of the American Academy of Pediatrics held a dinner meeting at 6:30 p. m. on Thursday, April 29th, at which Dr. Stanley Nichols, Asbury Park, Chairman of the Academy, discussed the question—"How can the Fellows of the American Academy of Pediatrics best forward the improvement of child health in New Jersey?"

SCHOOL PHYSICIANS

The New Jersey Association of School Physicians held its first annual meeting on the afternoon of Thursday, April 29th, first attending the meeting of the Pediatric Section, when Dr. H. B. Silver, Newark, discussed the subject "The School Physician".

The members of the association then held their own session, when Dr. A. H. Horland, Newark, discussed the subject "The Public Health Value of the School Physician".

The association then held a business session for the election of officers and the adoption of policies for the coming years. Officers elected were:

President, H. B. Silver, Newark
Secretary, A. H. Horland, Newark

C. SECTION ON GASTRO-ENTEROLOGY

LOUIS L. PERKEL, *Chairman*, Jersey City
S. BERNARD KAPLAN, *Secretary*, Newark

The Section on Gastro-Enterology held its meeting on the morning of Wednesday, April 29th, 1937, and carried out the following program:

1. Clinical Manifestations of Ingestion Allergy
   Joseph D. Goldstein, M.D., Jersey City
   Discussors: Hyman Goldstein, M.D., Camden; Dean Marquis, M.D., East Orange
2. The Pathology of Intestinal Amebiasis
   Thomas T. Mackie, M.D., New York City
   Discussor: Manfred Kraemer, M.D., Newark
3. Certain Aspects of Peptic Ulcer
   John L. Kantor, M.D., New York City
   Discussor: Sigurd Johnsen, M.D., Passaic
4. Ulcerative Entero-colitis in Tuberculosis

George G. Ornstein, M.D., New York City
Emil Granet, M.D., New York City
Discussor: Abraham E. Jaffin, M.D., Jersey City

5. Tuberculosis of Ano-rectal Region
Julius Gerendasy, M.D., Elizabeth
Discussors: Carroll D. Smith, M.D., Paterson; Emil Granet, M.D., New York City

Officers for the year 1937-1938 were elected as follows:

Chairman, S. Bernard Kaplan, Newark
Secretary, Manfred Kramer, Newark

The following members attended the meeting of the Section on Gastro-enterology, according to a registry kept at the door of the meeting room:

Name	*City*
T. T. Mackee	New York City
Arthur M. Kraut	Jersey City
J. D. Goldstein	Jersey City
L. L. Perkel	Jersey City
R. V. Gorsch	New York City
Dean Marquis	East Orange
George M. Levitas	Westwood
Nicholas M. Alter	Jersey City
Louis G. Shapiro	Paterson
Isaac Gelber	Union
Albert G. Market	Paterson
Sydney Rosenthal	Newark
Reuben J. Holland	Linden
F. N. Bunnell	Barnegat
E. A. Cameron	East Orange
Benj. Sherman	Morristown
Albert Van Sickle	Chester
J. L. Mathesheimer	Jersey City
L. Noll	Irvington
S. W. Johnsen	Passaic
J. H. Lowrey	Newark
F. L. Perry	Woodstown
S. Bernard Kaplan	Newark
E. Klein	Newark
M. Kraemer	Newark
J. Granet	New York City
Abraham E. Jaffin	Jersey City
Charles H. Reinacher	Newark
C. M. Trippe	Asbury Park
J. H. Bradshaw	Orange
W. J. Carrington	Atlantic City
Isaac East	Skillman
Jos. M. Kuder	Mt. Holly
Samuel B. Barishaw	Jersey City
A. J. Friedland	Woodbine
G. L. Becker	Paterson
W. L. Mortensen	Culver City, Cal.
A. W. Justin	Weehawken
John S. Irvin	Atlantic City
F. J. Altschul	Long Branch
E. Katzin	Newark
R. R. Armstrong	Passaic
P. E. RePass	East Orange
J. M. Schildkraut	Trenton
H. I. Goldstein	Camden
C. D. Smith	Paterson
E. P. Darlington	New Lisbon
W. J. Sweeney	Weehawken
C. A. Schneider	Newark
J. E. Runnells	Scotch Plains
E. B. Beairsto	Trenton
H. M. Glasston	Linden
C. H. Wintsch	Newark
F. C. Weber	Newark
Edward C. Klein, Jr.	Newark
Francis M. Clarke	New Brunswick

D. SECTION ON RADIOLOGY

W. W. MAVER, *Chairman,* Jersey City
P. S. AVERY, *Secretary,* New Brunswick

The Section on Radiology met the morning of Wednesday, April 28th, 1937, and carried out the following program:

1. The Treatment of Infections by X-ray
C. F. Baker, M.D., Newark
W. J. Marquis, M.D., Newark

2. The Principles of the Coutard Technic
Milton Friedman, M.D., Newark

3. The Care of the Cancer Patient
Elwood E. Downs, M.D., Woodbury
Hoke Wammock, M.D., Philadelphia
Ralph T. Artman, M.D., Philadelphia

4. The Treatment of Lung Abscess by Means of Guaiacol Intravenously
Charles H. Nammack, M.D., New York City

5. The Value of Colloidal Thorium in Radiological Practice
Raphael Pomeranz, M.D., Newark
Exhibit: The Visualization of the Radiological Practice.

6. A Roentgen Survey of the Colon
N. J. Furst, M.D., Newark
L. J. Gelber, M.D., Newark

7. Subdiaphragmatic Abscess
W. W. Maver, M.D., Jersey City
Charles Oderr, M.D., Jersey City

Officers for 1937-1938 were elected as follows:

President, J. D. Tidaback, Summit
Vice-President, Milton Friedman, Newark
Secretary, P. S. Avery, New Brunswick

3. SCIENTIFIC EXHIBITS

The Scientific Exhibit, conducted by a special committee with Dr. Asher Yaguda, Newark, Chairman, has become one of the most popular and valuable features of recent Annual Meetings. It was located in one of the largest rooms of Haddon Hall, within easy access to all the members. The Medical Society of New Jersey has provided spacious booths, which are stored between the Annual Meetings, and are especially designed to provide wall spaces, tables, and above all, excellent lighting.

The exhibit room was thronged with visitors at all hours, who found demonstrators ready to explain the exhibits. Each visitor was enabled to talk to the demonstrators and to learn the scientific principles which the exhibit illustrated.

Prizes were awarded for the best exhibits, as is reported by Dr. Yaguda in Section 37, page 41 of the Transactions.

A full list of exhibitors was printed in the program, and in Dr. Yaguda's annual report on page 242 of the April Journal.

Following the precedent of 1936, illustrated articles on the exhibits will be printed in the Journal from time to time throughout the coming year.

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4. HISTORICAL EXHIBIT

Following the publication of a series of Journal articles on the Medical History of New Jersey, the Woman's Auxiliary made "Medical History" a feature of its exhibit of Arts, Hobbies, and Medical History. This year there was an extensive response to appeals for historic material, which is described in the Transactions of 1937, page 100.

The county societies are showing a keen interest in the early histories and in the biographies of their prominent members, evidence of which is the biographical articles in the June Journal, page 396.

The Historical Exhibit at the Annual Meeting is an inspiration to all the members of the medical societies to collect, preserve and catalogue the historic material which is now available, provided an organized effort is made along historic lines.

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5. TECHNICAL EXHIBITS

The technical exhibits were more extensive and interesting than ever before. They were located in a spacious room and hallway through which the members passed on their way to the registration table and the Scientific Exhibits.

The exhibits numbered 32, and were listed in the April Journal, page 287. The opportunities to see the newer instruments and preparations which every doctor uses, to hear their importance explained, and to make the acquaintance of the dealers were fully appreciated by the members. And finally, the exhibits were an important source of revenue to The Medical Society of New Jersey, under the management of Mr. J. B. Tufts.

PUBLICITY OF THE ANNUAL MEETING, 1937

A REPORT OF THE ACTIVITIES OF THE PUBLIC RELATIONS COMMITTEE

By Joseph H. Kler, M.D., Chairman

"Public opinion for good or for bad is shaped by propaganda. People use one toothpaste or another, not because of the merits of the products, but because of propaganda. * * * Today the physician no longer needs to hide his methods or his knowledge. Medical practice has become far too technical for lay immitation."

In these words Dr. Howard W. Haggard tried to point out the necessity for frank and honest publicity. Recent events show that Dr. Haggard was more of a prophet than we realized. In this changing social order, we need the understanding of the people if we expect them to have confidence in us, and to trust us in the development of more effective methods of distributing medical care to all people. The Annual Meeting was an excellent starting point; and to secure the publicity that the program deserved was a challenge that we accepted.

NEWSPAPER RELEASES OF SCIENTIFIC ARTICLES

Now what did we have to offer to the public—through the medium of the press and the radio? Without exception the entire program was strictly technical, and certainly would not be understood by, nor would it even appeal to, the public in general. We therefore had to translate our information into understandable language. To do so, it was necessary to prepare news releases of the papers that were to be read at the meeting. The response of the men on the program was admirable. Ninety-eight per cent promptly sent us copies of their manuscripts. It is also interesting to know that our plans appealed to the "out-of-the-State" authorts. One sent the fallowing letter with his manuscript: "Thank you for your kind letter of April 8th. Permit me to congratulate you and your associates on the energetic way in which you are pushing the organization of your Annual Meeting."

As soon as the manuscripts were received, a well-trained journalist prepared the news releases under our direction. In this way we were certain that it would be written in the language of the press, and that it would be news-worthy.

Our plan in general was to have all our information for the press prepared and ready before the meeting started. We also hoped that some newspapers and some of the news services would send staff representatives to the meeting. These representatives could use our material and supplement it as they wished.

Four days before the Annual Meeting we sent complete copies of the prepared news releases to all daily papers, and to all weekly papers requesting them. In all, sixty-five complete sets were sent to the various newspapers throughout the State. Other copies were distributed to newspapermen at the Annual Meeting during press conferences held daily. Every assistance was given to the various staff correspondents in preparing their material.

With the plan organized we wrote to the editor of every newspaper in New Jersey, and to the large daily newspapers of New York City and Philadelphia. We also wrote to the News Services. In this letter we tried to point out the so-called high spots of the meeting, its purposes and its value in the safeguarding of the general welfare of the people. We also sent a copy of the official program.

Most of the daily papers were enthusiastic about the plans. Many gave valuable suggestions. The Managing Editor of a Passaic daily wrote:

"Although we will not have a staff man at the Medical Society's Atlantic City meeting, I feel we will get ample coverage via Associated Press, and such advance releases as your own press man may mail. I'm all the way for your program of education in public health; and right now I'm giving a little help to Doctor Vosburgh, of Passaic, in getting out publicity stuff for the Passaic County Medical Society. BUT—to get such matter into print—it must first be made *newsworthy*. If you intend doing the job right, get a man who knows news, and knows how to write it; and give him carte blanche. Then you'll get results. Until now, the news-timidity of the medical profession itself has been the chief damper put on public health news."

We were especially pleased to get this letter because our plans were in keeping with these suggestions.

RESPONSE OF THE NEWSPAPERS

The response of the newspapers was beyond our hopes. The Newark Evening News, Associated Press, United Press, New York Herald Tribune, Philadelphia Evening Public Ledger, and the Atlantic City newspapers sent staff representatives to the meeting. All were very cordial, and it was a pleasure to work with them.

Before the meeting we considered subscribing to a clipping service so that we might know how many newspapers carried articles about the meeting and how much they printed. However, we decided not to subscribe, for economic reasons. As a result, we have no accurate measure, but we do have much information that gives us definite knowledge of the results obtained. We know that practically all daily papers in the State printed something about the Society each day of the meeting. The New York daily papers and the Philadelphia papers were extremely generous with their space. The New York Herald Tribune printed almost as much about our meeting as it did about the meeting of the New York State Medical Society. Many of the weekly papers also carried certain articles.

REACTION OF THE EDITORS

The respose of the editors is best illustrated by the following letter, which we received shortly after the meeting:

"We are more than glad that the coöperation between the News and the medical men at Atlantic City worked out so successfully. For years I have wanted to see a better understanding; for years I have deplored the failure of the medical profession to appreciate the tremendous educational advantages of newspaper publicity. I know full well we have our shortcomings. I know things have been done which professional men do not like. I also know that some of the things so criticized have been done because of the failure of coöperation or because of the failure of medical men to understand what they could accomplish if they would turn newspaper publicity to their own good purposes. That a new deal has dawned is a matter of real relief and gratification. We will be glad at any time to receive your further suggestions."

A letter of this character, coming from the editor of one of our largest newspapers, means much. We can accept it as an index to the worth of our program.

REACTIONS OF THE PUBLIC

The reactions of the public in general also is difficult to interpret accurately. However, we have made inquiries throughout the State, and can report that the people in general were very interested in the publicity. They not only read it, but looked forward to the next day's material.

REACTIONS OF PHYSICIANS

The impressions and experiences of physicians were also interesting. Many physicians reported that their patients came to their offices to discuss health matters as a result of the newspaper publicity. One physician wrote to the committee and commented upon the response of his patients, and upon his own impressions.

RADIO PROGRAM

Three broadcasts over Station WPG were given during the progress of the meeting. The first broadcast was designed to describe the purposes of the meeting and the various exhibits; the second, to describe the progress of the meeting and the various topics under discussion; the third and final broadcast, to give a summary of the meeting and accomplishments.

For the response to the radio program we must depend upon the impression of the managers of Station WPG. It was their opinion that the response was good, and that the program was more than worthwhile.

BASIS FOR FUTURE PLANS

In conclusion, we may state that the publicity program was an experiment that was necessary because of the social changes taking place in our country. The experiment as planned proved successful beyond our hopes. We have every reason to believe that it can be made even more effective as the committee gains in experience and as all newspapers learn that our motives are sincere.

On the basis of this year's experience, we believe that a program of publicity can be developed, in coöperation with the newspapers, that will be of fundamental importance in the evolution of future programs of application of medical services. We need to mold public opinion because our profession alone understands the problem of distribution of medical services. However, we need to remember the changing social orders in which the people are constantly becoming more vocal and more assertive. Patients no longer consider themselves the property of the physician, but rather as the beneficiaries of the procedures employed by the physician.

Please consider our efforts as a beginning of a program that should be both happy and fruitful in future meetings.

PART THREE
THE WOMAN'S AUXILIARY
TO
THE MEDICAL SOCIETY OF NEW JERSEY
TENTH ANNUAL MEETING, IN HADDON HALL, ATLANTIC CITY, APRIL 27-29, 1937

The *Woman's Auxiliary to The Medical Society of New Jersey* held its tenth annual meeting in Haddon Hall, Atlantic City, at the same time that the Medical Society was holding its 172nd Annual Meeting. The leaders shared in the social events of the doctors, and sponsored the formal Banquet and Ball in honor of the President. The Journal of May, page 365, carried a brief outline of the meeting, and a longer article describing the Art, Hobby, and Medical History Exhibit.

The activities of the Auxiliary are becoming standardized, and projects of intrinsic worth are being carried out.

The sessions of the Auxiliary were conducted with a skill and smoothness that reflects the experience of the leaders through former years, in methods of transacting business by actual participation in meetings, and by trial of plans in competition with other groups who are promoting public activities.

The Woman's Auxiliary has a central objective in its Exhibit of Arts, Hobbies, and Medical History. Mrs. Beir and her committee have brought out a surprising number of mementos that suggest a wealth of historic memories and hours of devoted labor by those whose interest is along the lines of history and art. And the most encouraging aspect of the exhibit is its extensive growth and development. The Journal will be glad to record the studies and findings of the local auxiliaries.

It is most encouraging to find that a considerable number of auxiliaries are coöperating actively in promoting health lectures through their own Speakers' Bureaus. They will find plenty of doctors willing to deliver lectures, provided the arrangements for them are made by the auxiliaries as press agents and lecture bureaus representing the physicians.

The officers and committeemen of the Auxiliary are to be congratulated on the progress of the organization during the past year and the achievements which demonstrate the value of the projects of the Auxiliary.

THE EXECUTIVE BOARD
MINUTES OF THE PRE-CONVENTION MEETING

The Pre-convention Meeting of the *Executive Board* of the Woman's Auxiliary to The Medical Society of New Jersey was held in the Mandarin Room in Haddon Hall, Tuesday, April 27th, 1937, at 2:30 p. m. The President, Mrs. George A. Rogers, presided.

It was moved, seconded and carried that as a copy of the minutes of the previous meeting had been sent to each member of the Board, the reading of them should be dispensed with.

A. M. A. FUND

The Treasurer's report was read by the Recording Secretary, recording a deficit of $151.75 in the A. M. A. Fund.

A motion was made, seconded and carried that a check for thirty dollars ($30.00) be sent to Mrs. Carl Surran for the Annual Meeting Fund.

There was a discussion as to how the deficit in the A. M. A. Fund was to be met.

There was a motion that the President appoint a committee to learn just what moneys would be needed, and that this amount be prorated to the counties according to membership; that in cases where the contribution from the county is less than the prorating, such county be asked to make up the difference.

This was seconded and carried.

REPRESENTATION IN NATIONAL AUXILIARY

The President requested information on the question of who represents the State Auxiliary at the National Meeting in June, when such meeting is held prior to the regular meeting of the State Medical Society.

Mrs. A. Haines Lippincott moved, it was seconded and carried, that the President who has served throughout the year shall represent the Auxiliary unitl after the National Meeting.

RELATIONS TO THE STATE FEDERATION OF WOMEN'S CLUBS

A communication from the State Federation of Women's Clubs, in reply to an inquiry as to club privileges in that organization, was read. Mrs. Lippincott stressed the importance of the Auxiliary's contact with the Federation: that the members should keep themselves informed on any resolutions to be acted upon; and that should any such resolution be detrimental to the medical profession, the Auxiliary should do all in its power to defeat it.

After the reading and discussion of the resolutions to be acted upon by the Federation at its meeting in May, it was regularly moved, seconded and carried that the Delegates be instructed to vote for all of them.

These resolutions are filed with these minutes.

FACILITIES OF THE EXECUTIVE OFFICES

Mrs. Rogers asked that resolutions be sent to Dr. Wilkes and Dr. Overton, expressing the deep appreciation for their untiring coöperation during the year. Upon being informed that Miss Soden, Secretary, had been most helpful in preparing the calendar for the year (Journal, April, p. 305), Mrs. Rogers had written her a letter of thanks.

Mrs. James Hunter reported that she had written Dr. Wilkes in regard to the question of filing the archives of the Auxiliary, and that she was informed that space in the Executive Offices was at a premium. She suggested that the care and preservation of the archives should be in a centrally located place, preferably Trenton.

There was a discussion as to possible plans for filing of same, but no conclusion was reached.

No further business was presented. The meeting adjourned.

Respectfully submitted,

MRS. DAN S. RENNER.
Recording Secretary.

ANNUAL MEETING

April 28, 1937.

The Tenth Annual Meeting of the *Woman's Auxiliary to The Medical Society of New Jersey* was held in the Tower Room of Haddon Hall, Wednesday, April 28th, 1937, at 9:30 a. m. The President, Mrs. George A. Rogers, presided.

The minutes of the Ninth Annual Meeting were read and approved, with an expression of appreciation from the Board to Mrs. Ely for such a full report.

TREASURER'S REPORT

Mrs. Thomas P. McConaghy, due to an indisposition—though in the hotel, to be contacted when necessary—was unable to attend the session. Her report was read by the Recording Secretary. It showed balances in the General Meeting Fund as follows:

In the General Meeting Fund	$278.13
In the A. M. A. Fund	177.36
In the bank	303.74
There was a deficit in the A. M. A. Fund of	$151.75

ARRANGEMENTS

Mrs. J. H. Hornberger, after presenting her report for the year, expressed her appreciation to the local chairmen for their coöperation.

ARTS AND HOBBIES

Mrs. Ily R. Beir, after reading her report, thanked all those who had assisted her in any way.

Mrs. Rogers expressed her appreciation for Mrs. Beir's untiring efforts, and asked the members to show their appreciation by attending the tea and listening to the talk to be given by Dr. Overton in the afternoon.

ENTERTAINMENT

Mrs. Carl Surran gave a resumé of the entertainment planned by her committee. A vote of thanks was extended to her and her committee for their efforts in making the session a pleasant one.

LEGISLATION

Mrs. James McGuire stated that no legislative bills were presented other than those reported at the January meeting.

ORGANIZATION

Mrs. Don A. Epler reported a paid-up membership of 762, an increase of fifty members over that of the previous year. There are now 1106 members on the roll.

Dr. Wilkes had suggested that the Auxiliary was well organized for augmenting the medical program of health education.

Mrs. H. Roy Van Ness, having held her office but a short time, had not had time to do much along the line of health education. She urged that each member of the Auxiliary educate herself on health subjects.

ARCHIVES

Mrs. James Hunter again asked for suggestions for the care of the collection she had made. She had been in communication with Dr. Wilkes as to the possibility of storing the archives in the Executive Offices of the Medical Society, but had been informed that the storage place there was limited. It might be possible, if the Medical Society so approved, to store a small quantity in a space which need not be readily accessible. Mrs. Hunter thought that they should be in a place which could be reached easily. Dr. Wilkes' letter is on file with these minutes.

PUBLIC RELATIONS

Mrs. A. Haines Lippincott reported that she had been planning with the able assistance of Dr. Joseph Kler, Chairman of Public Relations of The Medical Society of New Jersey, a better method of filing the information of the contacts made by the Auxiliary with lay organizations; that the Speakers' Bureau was of necessity divided with the Program Chairman.

She emphasized again the importance of not sending the list of speakers to lay groups—that the Auxiliary members could have these lists by contacting Dr. LeRoy Wilkes, but only the subject matters should be given out.

She cautioned the counties about filing their signed questionnaires for future reference, and repeated the instructions about how to fill out and summarize the information to send to her. She asked that we check on our libraries to see that the approved book lists were posted.

ADDRESS OF DR. KLER

Dr. Joseph Kler, Chairman of Public Relation in the State Medical Society, was then introduced and gave a very inspiring talk on the strategic position held by the Woman's Auxiliary, explaining that it could bridge the gap between the medical profession and the lay groups, using as an example the case of Pennsylvania, where, when the Bill for Socialized Medicine was presented, the Woman's Auxiliary and all women's groups were contacted to fight the bill. As a result, the Congressmen were flooded with letters protesting the bill, and it was not allowed to come out of committee.

He suggested that we see to it that the names of the medical men and their wives who have attended medical meetings be sent to the local papers, and that we have their pictures inserted if possible.

His motto for us was, "Take one small job and do it well, rather than try to take too big a bite."

He asked that we try to arrange that each study group have at least one health speaker a year.

PRESS AND PUBLICITY

Mrs. O. R. Carlander stated that reports of the work of the Executive Board had been sent to "The New York Times", "The Herald Tribune", and "Philadelphia Inquirer";—that the notice of "The Five Minute Talks" had been sent to the "Club Woman"; and that a scrap book of the activities of the various Auxiliaries was being kept which would be complete with the news of the State Convention.

RESOLUTIONS

Mrs. Lancelot Ely presented resolutions expressing the appreciation of the Executive Board to Dr. Wilkes and Dr. Overton for their courtesy and unlimited assistance during the year.

WIDOWS AND ORPHANS

Mrs. Theodor Teimer reported that she had learned that some counties did not know about the Society for Widows and Orphans. She asked that each Auxiliary take one meeting to explain this to the members.

These reports of Chairmen of committees were accepted as read.

MEMORIAL SERVICE

Mrs. James Hunter then conducted a very appropriate Memorial Service to the following departed members:

Mrs. McAllister, Camden County, a Charter Member.

Mrs. John Sommerill, Salem County, wife of a physician, and mother of a physician.

Mrs. Barbara Small, Burlington County, wife of a physician, and mother of a physician.

Mrs. Rachel Walthouser, Essex County.

Mrs. John O'Neil, Hudson County.

Mrs. Elizabeth Ridge Cooper, Somerset County, wife of a physician, and mother of two physicians.

A roll call included eleven County Presidents, thirty-six members in all. A list of those present is filed herewith.

COUNTY REPORTS

The following counties presented their reports:

ATLANTIC

Mrs. D. C. Reyner, President

The Auxiliary had decided that instead of sending flowers to a physician's widow, they would present a book chosen from the approved book list as a memorial to the doctor.

Among the outstanding activities of the Atlantic County Auxiliary were a reciprocity tea, with the coöperation of the Woman's Club; health talks; and book reviews.

BERGEN

Mrs. Alvah Bickner, President, reported that the Speakers' Bureau was functioning well, and that a reciprocity meeting was planned for May.

BURLINGTON

Mrs. Dean H. LeFavor, President, reported that the Auxiliary had financed a scholarship for a student nurse. The speakers' bureau had functioned well in that it had supplied twenty-five speakers during the year. The Auxiliary had conducted a reciprocity tea, and a public relations survey.

CAMDEN

Mrs. Robert S. Gamon, President, reported that a public relations meeting had been held; eighteen speakers had been supplied from the speakers' bureau; and the Auxiliary had assisted in promoting a Child Welfare Institute, coöperating with the County Medical Society.

ESSEX

Mrs. Frederick G. Shaul, President, reported a reciprocity meeting and a public relations tea.

GLOUCESTER

Mrs. Don B. Weems, President, reported that the Auxiliary's activities were essentially social by request of the County Medical Society.

HUDSON

Mrs. A. E. Jaffin, President, reported the offering of the five-minute talks to lay organizations; a venereal disease campaign; a circulating library; and publishing a small pamphlet edited by a member, containing Auxiliary news.

MERCER

Mrs. C. Chester Chianese, president, reported a public relations tea.

INTRODUCTION OF PRESIDENT SNEDECOR

Here Dr. Quigley introduced the President of the State Medical Society, commending him for his work as President, Dr. Spencer T. Snedecor, who expressed regret that, due to a meeting of the House of Delegates at the hour of the Auxiliary Luncheon, he would not be able to address us then. He commended the Auxiliary for its splendid work, and gave it much credit for the record attendance at the convention.

Mrs. Rogers replied that the success of the Auxiliary was due in great part to the interest and coöperation of the President of the State Medical Society.

The reports of the County Presidents were then continued:

MIDDLESEX

Mrs. J. J. Mann, President, said that the Auxiliary showed splendid progress in the few years it had been organized. The past year it could report progress in public relations and in public health activities, having supplied, through the speakers' bureau thirty-eight lay groups with speakers.

MONMOUTH

Mrs. H. H. Freedman, President, reported having used the five-minute talks.

OCEAN

Mrs. Theodore F. Thompson, President, reported having held three meetings during the year, one of which was devoted to health education. Other activities were limited owing to the great distances.

PASSAIC

Mrs. L. R. Taber, president, reported having had book reviews and a public health meeting, and had devoted much effort in securing subscriptions to Hygeia.

SOMERSET

Mrs. W. B. Gray, President, stated that the Parent-Teachers Association had promised to coöperate this coming year in using the speakers' bureau and the five-minute health talks.

UNION

Mrs. F. B. Gilpin, President, reported health meetings. The outstanding achievement was in winning the $50.00 prize offered by Mrs. Fitzgerald for procuring the most subscriptions for Hygeia of any county.

She also reported holding a reciprocity tea.

WARREN

Mrs. James Weres, President, reported that this recently formed Auxiliary now has fifteen members.

CONSTITUTION AND BY-LAWS

Mrs. Frederick Kinch read each article, which was approved as read; then moved the adoption as the whole. This was seconded and carried.

It was moved, seconded and carried that these be printed and distributed.

PRESIDENT'S REPORT

Mrs. G. E. McDonnel, Second Vice-President, presided while Mrs. Rogers read her report of the activities of the year. Her report is filed with these minutes. It was moved, seconded and carried that this report be published in the Medical Journal by permission of the Executive Office. (See next article.)

NOMINATING COMMITTEE

Mrs. F. A. Kinch presented the following slate:

For President-Elect, Mrs. Don A. Epler, Essex
For First Vice-President, Mrs. A. E. Jaffin, Hudson
For Second Vice-President, Mrs. G. E. McDonnel, Burlington
For Recording Secretary, Mrs. Dan S. Renner, Somerset
For Treasurer, Mrs. Thomas P. McConaghy, Camden
For Directors for three years:
Mrs. Chester I. Ulmer, Gloucester
Mrs. B. M. Howley, Middlesex
Directors holding over:
Mrs. Alvah Bickner, Bergen
Mrs. A. L. Stillwell, Somerset
Mrs. Murray Waranof, Monmouth
Mrs. LeRoy A Wilkes, Mercer

It was moved, seconded and carried that the nominations be closed.

The Secretary was directed to declare the election of these officers. The officers nominated were declared elected.

Mrs. Rogers then introduced the newly elected officers, expressing regret that Mrs. McConaghy, the Treasurer, was unable to be present.

She then presented Mrs. Samuel Salasin, the newly elected President, who read her address (see page 102), containing some of the plans for the coming year. Her report is filed with these minutes.

No other business was presented. The meeting was adjourned.

Respectfully submitted,

MRS. DAN S. RENNER,
Recording Secretary.

REPORT OF THE STATE PRESIDENT

MRS. GEORGE A. ROGERS, East Orange, N. J.

As President of the State Auxiliary, my duty is not to give a detailed account of work undertaken, or the methods used in their accomplishment, as this may be read in the reports of the County Presidents. My part is to give a summary of what has been done, and a brief outline of the performance of the duties pertaining to my office.

In the matter of our *public relations* work, I may say that there has been distinct progress. The total number of lay groups contacted during the year is approximately 350.

Under the able guidance of the State Chairman, Mrs. Lippincott, the County Chairmen have been putting forth notable efforts to expand this program and make our contacts far-reaching.

Our Speakers' Bureau is much better organized this year and has been of great service to many of the counties.

The Public Health Department is developing an extensive program ready to be followed next year.

These two committees are the backbone of the Auxiliary structure; and unless their programs are well planned and faithfully carried out, it will inevitably collapse.

Organization this year has not meant bringing more counties into the Auxiliary,—they are not yet ready to come; but important work has been done in gathering together statistics necessary for complete and accurate files.

Follow-up work dealing with the proper functioning of the Auxiliaries has also been part of the program of this committee.

All of us who had a share in compiling the State booklet feel rewarded for our trouble by the enthusiastic reception given it by Auxiliary members. Thanks are due Dr. Wilkes for suggesting it. (Journal, April, p. 305.)

The individual correspondence connected with this office is large and varied, and has been promptly attended to. I wish I could say the same concerning replies from county officers to necessary communications. Prompt response would save time and postage. My grateful thanks to those who realized their responsibility.

Upon invitation, many counties have been visited. The kindly welcome and gracious hospitality of Presidents and members made these visits occasions to be remembered with great pleasure.

In June here in Atlantic City there will be the convention of the national organization of the Auxiliary. I urge all members who possibly can to come.

Meeting with members from all other State Auxiliaries and hearing their reports, problems, and achievements give us a real inspiration, or I should say aspiration, to do more and better work.

The increase in our membership from 712 to 762 is gratifying, but falls far short of the one hundred per cent goal. However, I believe that the spirit of progress pervades all the Auxiliaries, and that none will be satisfied unless able each year to show an increase in membership and a wider scope of work to be accomplished.

In closing my report, I want to heartily thank all the officers, State Chairmen, and board members who have worked so harmoniously with me; and who have put forth their best efforts to make this a successful year.

Loyalty to the purposes of the Auxiliary with forgetfulness of self-interest is the moving spirit of the organization.

Respectfully submitted,
Ethel M. Rogers.

FINAL REPORT OF THE ART, HOBBY AND MEDICAL HISTORY COMMITTEE

The use of the Benjamin West Room to house our exhibition this year was an immense success from every point of view. My forecast of a large increase in the number of exhibits was more than borne out; and though our floor space was doubled, it was not too much.

There were no complaints of inadequate lighting, and every article in every part of the room could be well seen. Even the paintings had good light without glare or reflection.

The hotel management contributed much by lavish use of palms, rugs, comfortable chairs, and efficient service.

The room was open daily from 8:30 a. m. to 6 p. m.; and after following the public meeting on the night of April 27th, it was kept open for several hours and was thronged with visitors.

Being on the same floor as that where the meetings of the Auxiliary were held added convenience; and it was noted that, whereas in former years visitors sat, talked, or wrote, this year they wandered from exhibit to exhibit instead. This seemed to be evidence of increased interest in the exhibition.

As will be seen from the figures appended, the number of exhibitors nearly doubled and the exhibits quadrupled, in contrast with those of 1936.

County Medical History Committees made their first showing this year; and we are proud that nine of the sixteen Auxiliaries were represented. We hope that observation of these exhibits will instruct and encourage the others to enter next year.

The room was arranged so that the Medical History Exhibit would be the first to strike the eye upon entering, being grouped on the far wall of the room. In the center was a collection of twenty-five photos of Past Presidents of The Medical Society of New Jersey, and flanking this were the County Medical History exhibits. Directly in front of these racks were three showcases containing exhibits of the Academy of Medicine of Northern New Jersey. Signs bearing names of counties were placed over their exhibits, and a large one identified the whole Medical History Exhibit.

At the sidewalls, a showcase was placed at each window embrasure, and between these were racks covered by photos, art pieces, and curiosities, while in front of the racks were tables laden with beautiful objects. The whole South wall was filled with paintings, etchings, drawings, and photos, as it had splendid light from both sides and the chandeliers. Thus the whole wall line was completely filled and two cases had to be placed in the center of the room. Twelve showcases were required.

On Wednesday, April 28th, Dr. Frank Overton, Editor of the Journal, gave another most interesting talk on Medical History to an audience double that of last year, after which tea was served to about 150 guests. Many officers of prominence in both the Auxiliary and the Medical Society graced this occasion by their presence and interest.

The guest register was signed by 403 visitors, of whom 45 per cent were men. Because of the throngs at many times, and the lines

waiting to register, many left without doing so, and probably less than one-third registered.

Though it was well merited, I was happy to learn of the interest and admiration the many beautiful, interesting, and unusual exhibits excited. Besides that of Dr. Edward J. Ill, and those of the State and counties, the collections of Indian relics, paintings, sculpture, glass, china, silverware, rarities of Japan and other countries, photos, old medical books, art goods, medical and other curiosities,—all vied with each other in their interest to visitors.

I am greatly pleased with the way Medical History Committees took hold, and hope for much more next year. I believe that this committee, through its County Medical History Committees, the Historians of the County Medical Societies, and the help of the State Medical Society officers and membership, will be able to gather and record Medical History material for both the annual exhibition and the Archives.

Am glad to report that this committee has again stayed within its appropriation.

As the Medical History work of this committee is a major objective of our Auxiliary, some of the County Medical History exhibits will be shown, as part of this State's exhibit, in the exhibition of the Exhibit Committee of the Woman's Auxiliary to the American Medical Association during its convention here June 7 to 11 this year.

DETAILS OF EXHIBITS AND EXHIBITORS

In 1936 nearly 500 articles were shown by forty-seven exhibitors, of whom thirty were Art and Hobby, while seventeen were on Medical History. We felt that this was a great increase.

This year 2072 articles were exhibited by eighty-eight entrants as follows:

Nine County Medical History Committees entered eighty-two articles; thirty individuals entered 181 Medical History exhibits; forty-nine entrants entered 1809 Art and Hobby objects.

COUNTY MEDICAL HISTORY COMMITTEE EXHIBITS

1. *Atlantic County*—List of Past Presidents of the County Medical Society; thirteen Biographies of Past Presidents mounted in pamphlet form with photos on cover, one without photo; Biography of Dr. Charles H. deT. Shivers; List of Medical Families in Atlantic, giving number of generations of doctors in each; Medical History of Atlantic County; Photo of Dr. Jonathan Pitney (first doctor in Atlantic); Bibliography and photo of Dr. George M. Gould; Photo of Dr. E. H. Harvey; Certificates of fifty years in practice of Drs. C. Garrabrand, C. J. Miller, and C. H. Shivers. Many medical antiques.
2. *Camden County*—Pamphlet of generations of medical families; two biographies and photos; two biographies only; list of presidents of State Medical Society from Camden; list of doctors in practice fifty years; facts regarding the County Medical Society; facts regarding the founding of the County Medical Society, May 12th, 1846; State Medical license to Richard M. Cooper, July 9th, 1846.
3. *Essex*—Biography and photo of Dr. John F. Hagerty; photostat of proceedings at First Meeting of the State Medical Society in New Brunswick, July 23rd, 1766; Photo of Cow Horn Milk Bottle; old monographs by Dr. Wells P. Eagleton.
4. *Gloucester*—Photos and biographies of Drs. L. F. Halsey, L. M. Halsey, H. B. Diverty, E. G. Hillegas; Biography of Dr. G. C. Law; Photostat Original Minutes Gloucester County Medical Society; Photo group and program at 100th aniversary of County Medical Society, in 1918; fifty-year certificate of Dr. E. Z. Hillegas; Reproduced photo of H. B. Diverty with three groups.
5. *Hudson*—"Entre Nous", monthly publication of Hudson County Auxiliary, edited by Mrs. L. L. Perkel.
6. *Monmouth*—Dr. Hubbard's old ledger, 1791; Archives Book containing great amount of statistics, etc., respecting doctors of this county; "Wills Physic", 1684; minute book of Monmouth County, 1816; Marrow's Surgery of 1685; measuring scale, 1830; old Midwifery Book; mortar and pestle, 150 years old; pocket prescription scale of 1885; old stethescope; photo Monmouth County Medical Society 1893.
7. *Passaic*—History County Auxiliary; yearly lists of staff St. Joseph Hospital, Paterson; three biographies; old book by Dr. James M. Stewart.
8. *Somerset*—Hunterdon and Somerset County History, 1881.
9. *Union*—Auxiliary scrap book; photo of Dr. Joseph B. Harrington, who is attending his sixty-second consecutive meeting of the State Society.

MEDICAL HISTORY ENTRIES BY INDIVIDUAL ENTRANTS

1. By Dr. Edward J. Ill and the Academy of Medicine of Northern New Jersey—Fifteen ancient medical books, including Gruningers Surgery of 1497, Pharmacopoea Wirtenbergica 1771, Paracelsus 1771, Malpighii's Anatomy 1697, Avicenna 1608, Mangate's Anatomy 1716, Eustachii's Anatomy 1744, Malpighii's Surgery 1687 (First Anatomy of Kidneys), Savonarolae's Fevers 1543, Harveo's Creation of Animal Life 1651, his Surgery 1766, Ruyschei's Anatomy 1721, Morgagni 1779; Dr. W. S. Disbrow's Collection of about fifty Commemorative Medals; Collection of old pessaries.
2. By Dr. F. A. Kinch—Photo of Dr. Joseph B. Harrison (Jour., May, p. 342); turnkey for pulling teeth; gum lancet; root extractor.

3. By Dr. H. L. Harley, Historian Atlantic County Medical Society— Sketch of life of Dr. Job Braddock Somers; List of Atlantic County medical families, with number of generations of doctors in each; medical history of Atlantic County; bibliography and photo of Dr. George M. Gould.
4. Dr. C. Garrabrand—Photo Dr. Jonathan Pitney; scarifier of Dr. Pitney; certificate of fifty years in practice of Dr. Garrabrant.
5. Dr. Clyde M. Fish—Photo Dr. Harvey with Sir H. Gladstone; old medical account book; diploma of his grandfather, 1838.
6. Dr. Imre Kemeny—Old medical book.
7. Dr. Milton Miller—His certificate of fifty years in practice.
8. Dr. C. H. deT. Shivers—Certificate of fifty years in practice of his father.
9. Mrs. James Hunter—Old medical bill; two cases of old instruments.
10. Mrs. B. A. Livengood—Old prescription formula book; six documents and six photos; old apothecaries cabinet and scale.
11. Dr. J. B. Morrison—Original seal of The Medical Society of New Jersey, adopted shortly after the Charter was granted in 1776; Billroth Austrian coin of 1820,—the only instance in medical history of a doctor's head on national currency.
12. Mrs. John F. Hagerty—Photo and biography of her husband.
13. Mrs. G. Milton Knowles—Old medical book of 1832.
14. Dr. Frank Overton—Photostats of proceedings at the first meeting of The Medical Society of New Jersey at New Brunswick July 23rd, 1766; photo cowhorn bottle for feeding babies; monographs Dr. Wells P. Eagleton.
15. Dr. LeRoy A. Wilkes for The Medical Society of New Jersey—Twenty-five framed photos of Past Presidents of The Medical Society of New Jersey.
16. Mrs. Edward C. Pechin—Very old treatise on domestic medicine.
17. Mrs. Louis L. Perkel—"Entre Nous" (Auxiliary Bulletin of Hudson County).
18. Mrs. Isabelle Somers—Medical History of Atlantic County.
19. Mrs. William B. Gray—History Hunterdon and Somerset Counties, 1881.
20. Mrs. C. B. Russell—Old medical book.
21. Mrs. Ralph J. Belford—Old medical book.
22. Mrs. Allan Rieck—Godey's Lady's Book, 1847.
23. Mrs. Don Agar Epler—Two books on pathologic anatomy 1885; Old Lancet; eyeglasses of 1834; Armstrong on fever.
24. Mrs. William G. Herrman—Pocket prescription scale.
25. Dr. Lawrence A. Wilson—Dr. Jonathan Pitney's cane, dress shirt, two photos, five dental instruments, spectacles, scale, funnel, pair eye glasses, and other instruments of Dr. Pitney.
26. Dr. Alexander McAllister—Antitoxin syringe; photo fiftieth anniversary Camden County, 1886.
27. Mrs. Harry F. Hubbard—Case of old instruments.
28. Dr. F. L. Field—Two old stethoscopes, one wooden.
29. Dr. Hadden—Very old mortar and pestle.
30. Dr. William K. Campbell—Three old books.

ART AND HOBBY EXHIBITS

1. Mrs. James Hunter—Old spectacles.
2. Ethel A. Roberts—One placque.
3. Mrs. F. A. Kinch—Banner of flag; old pocket of 1803; one painting.
4. Dr. B. E. Failing—Burl top mahogany coffee table, made by self.
5. Mrs. William W. Maver—Two paintings.
6. Dr. Clyde M. Fish—Large candelwick spread; arithmetic book of 1841; old walking stick; carpet bag; patchwork crib quilt; tea box pattern; two hand-painted patchwork quilts.
7. Mary Lea Davis—One water color; four paintings; one pastel; one painting on wood.
8. Mrs. James R. Harmon—Two large photo studies.
9. Mrs. J. Harris Underwood—One landscape, silk embroidered.
10. Mrs. Joseph Pantaleone—Two charcoal drawings.
11. Mrs. Harry E. Hubbard—Handwoven table cover, over 100 years old; one oil painting.
12. Dr. William Carlos Williams—Two books of short stories, by himself.
13. Mrs. G. Milton Knowles—Old history book of 1795.
14. Mrs. Peter Marvel—Old book 1789; geography book 1818; old arithmetic book; Sheraton clock; newspaper of 1862, "The Christian Banner"; parchment deed; brass Chinese incense urn.
15. Mrs. Stanley McGeehan—Silver fish set; hand-painted china punch bowl; hand-painted tea set (three pieces); two antique Japanese salts.
16. Mrs. D. M. Yazujian—Two pen and ink drawings.
17. Mrs. Herman Kline—Two Norwegian Viking boat salts.
18. Mrs. E. Harrison Nickman—Three old Dutch silver pieces; four Japanese silver salts; nine pieces early Spode china; antique Viennese fan; Japanese priest robe; large Japanese tie work square; old Japanese kimona; Japanese embroidered square; eight Japanese silk prints.
19. Mrs. Harry Subin—Three delft pieces; one Wedgewood plate; 1000-eyed bottle; old ink bottle.
20 and 21. Drs. A. S. Wescoat and R. Woolbert—One five-foot, and one three-foot case of Indian arrowheads, from tiny bird size to combat ones; implements; cups; idols; battle axes; pottery; wampum; microcephalic Indian skull and many other pieces, probably over 1500 pieces in all.
22. Mrs. C. Chester Chianese—Two white embroideries.
23. Dr. Louis L. Perkel—Twelve large photo studies.
24. Ethel Hausman—One wood carving; two small pastels; one oil painting.
25. Mrs. Walter Rullman—One-piece sculpture; two water colors; one wood engraving; one linoleum print.

26. Dr. David L. Farley—One bas relief wall placque of child's head.
27. Mrs. David B. Allman—One vase, 100 years old; one antique green glass goblet; three red glass decanters, Venetian.
28. Mrs. Allan Rieck—Two blue Stiegel glass vases; two pair green Jersey glass; one stoddard New Hampshire cream pitcher; two hobnail vases; one hobnail pitcher.
29. Mrs. George Augustus Rogers—About fifteen pieces currency; U. S. pieces of 1862, '63, '74, and 1776; shinplasters, confederate, and Cuban currency.
30. Dr. Lancelot Ely—Collection of twelve Indian pipes.
31. Dr. F. A. Kinch—Framed skeleton leaves.
32. Dr. Charles Teeters—Six pastel water colors.
33. Dr. C. C. Beling—Three oil paintings.
34. Dr. C. Abbott Beling—Three framed photo studies.
35. Mrs. B. A. Livengood—Four large photos on matts; one framed photo of Abraham Lincoln.
36. Dr. H. Lockwood—Two oil landscapes.
37. Dr. Dorothy Cross for N. J. Indian Site Survey—Twelve photos showing excavations at site; a five-foot case filled with a collection of Indian relics, pipes, arrowheads, implements, etc., dug up at sites. About seventy-five or more pieces. Mr. Luther Leonard was sent to personally be in charge.
38. Mrs. Thomas P. McConaghy—Two paintings on wood (pheasants); one painted tilt-top table.
39. Dr. Frederick J. Hughes—Two framed oil paintings.
40. Dr. Edward Uzzell—Eighteen sheets of Silver Jubilee of King George V stamp collection.
41. Mrs. Herschel S. Murphy (Helen Moore): "The Sampler of Progress", with typed "key" to same.
42. Mrs. Alfred Wallin—Hand-painted console set.
43. Mrs. Harry D. Cowlbeck—Queen Victoria Jubilee coin.
44. Mrs. Elizabeth Spencer—Two paintings.
45. Mrs. Levi M. Walker—Two paintings; one charcoal.
46. Mrs. Matthew Molitch—Nine large photos, scenes from New Jersey State Home for Boys.
47. Mrs. F. B. Gilpin—Old-fashioned bouquet, painted by grandfather, framed in mahogany.
48. Dr. Imre Kemeny—Two oils framed; five framed etchings.
49. Mrs. Vartan Kaschdorian—Two framed oil paintings.

Respectfully submitted,

Mrs. Ily R. Beir, *Chairman,*

Art, Hobby and Medical History Committee.

INAUGURAL ADDRESS

By Mrs. Samuel L. Salasin, Atlantic City, N. J.

I desire to take this opportunity to express my gratitude for the honor bestowed upon me. As President of this Auxiliary, I trust I shall have your coöperation, so that we may continue to serve our parent organization, The Medical Society of New Jersey. It is only by the absolute coöperation of each and every unit in this Woman's Auxiliary that accomplishments for good can be maintained. A chain is only as strong as its weakest link; and the criticisms that may arise because of any unit in the State will reflect upon the entire Auxiliary. I therefore urge that every County Auxiliary work in harmony for the welfare of the entire organization.

During the term of each of my predecessors some major service has been rendered to the community by its Auxiliary. Lest we forget, the primary purpose of the Auxiliary is to aid our parent organization. We should always be governed by it in the choice of our projects. We can accomplish nothing without definite objectives, approved by the State Medical Society.

The basic principles of this Auxiliary, as we all know, are:

First, to bring about unity and friendliness through good fellowship.

Second, to assist with entertainment at Medical Meetings and encourage acquaintanceship and better understanding between the various members.

Third, to stimulate a greater attendance of the doctors at medical meetings.

Our objectives for the coming year are:

1. To initiate and participate in programs for lay groups, especially women. Under this category comes Parent-Teachers Associations, Summer round-ups for physical examination, and lectures on medical topics.

2. To interest ourselves in those projects which are now adopted by the State Medical Society; and to aid where possible, if acceptable to them. Under this heading may be placed *our* self-education as well as the education of the public in matters of public health. This includes Immunization, Vaccination, Per-

iodic Health Examination, Venereal Disease Control, and the like.

Another very important project is the Medi-History of New Jersey. This requires organized effort in the compilation of the records of the Society, the various publications of its members, and the biographical data.

To execute these objectives it is necessary that each County formulate Conference groups for the promotion of Health Education and Public relations in our State, with the participation of members of our State Medical Society. These two programs are so interwoven that it is impossible to separate them. From time to time, there will be brought to your attention proposed legislation in which you, as wives of physicians, should be intensely interested. Your influence, for or against, such proposed legislation, will be of great value to the entire medical profession of the State.

Organization should make great strides during this coming year. The major trend of economic conditions is upward. We should endeavor to inspire enthusiasm. Try to reunite former members, and to secure the membership of every eligible doctor's wife. An active membership campaign should be instituted to organize several new Auxiliaries. This we can do with the aid of the respective County Medical Societies.

As President of your Auxiliary I am but one individual, and my accomplishments will be in direct proportion to your assistance and coöperation.

I feel assured that I will continue to receive the support that you have given to those who have preceeded me. For this I will be very grateful, and hope that our united efforts will ensure a most successful year to come.

WOMAN'S AUXILIARY
THE POST CONVENTION MEETING

A Meeting of the New Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey, was held in the Mandarin Room of Haddon Hall, Thursday, April 29, 1937, at 11:30 a. m. The President, Mrs. Samuel Salasin, presiding.

The following Members were present:

Mrs. Samuel Salasin ..... President
Mrs. Don A. Epler ..... President-Elect
Mrs. G. E. McDonnell ..... 2nd Vice-President
Mrs. Alvah Bickner ..... Director
Mrs. B. M. Howley ..... Director
Mrs. Chester I. Ulmer ..... Director

Mrs. G. A. Rogers ..... Advisory Board
Mrs. Frederick Kinch ..... Advisory Board
Mrs. H. V. Hubbard ..... Advisory Board
Mrs. A. J. Casselman ..... Advisory Board

CHAIRMEN OF COMMITTEES

Mrs. Ily R. Beir ..... Arts and Hobbies
Mrs. James Hunter ..... Historian
Mrs. Frederick Kinch ..... Printing
Mrs. A. Haines Lippincott .... Public Relations
Mrs. Lancelot Ely ..... Resolutions
Mrs. Theodore Teimer .... Widows and Orphans
Mrs. H. Roy Van Ness ..... Program (Health Education)
Mrs. David B. Allman ..... Credentials

COUNTY PRESIDENTS

Mrs. Lawrence A. Wilson

The President presented the list of appointed Chairmen of Committees for the approval of the Executive Committee as follows:

Arrangesments—Mrs. A. Schulman, Jersey City
Archives—Mrs. Charles F. Adams, Trenton
Arts and Hobbies—Mrs. Ily R. Beir, Atlantic City
Credentials—Mrs. David B. Allman, Atlantic City
Historian—Mrs. James Hunter, Westville
Legislation—Mrs. LeRoy A. Wilkes, Trenton
Nomination—Mrs. George A. Rogers, Newark
Organization—Mrs. J. H. Hornberger, Roebling
Parliamentarian—Mrs. H. D. Corbusier, Plainfield
Press, Publicity—Mrs. A. R. Carlander, Merchantv'le
Printing—Mrs. F. A. Kinch, Westfield
Public Relations—Mrs. A. H. Lippincott, Camden
Resolutions—Mrs. Lancelot Ely, Somerville
Widows, Orphans—Mrs. Theodore Teimer, Newark
Corresponding Sec.—Mrs. James Mason, Ventnor
Entertainment—Mrs. Carl Surran, Atlantic City

These were approved by acclamation.

It was reported that the House of Delegates of the State Medical Society had passed a resolution to disregard the magazine "Hygeia", for that reason the Executive Board, by acclamation dispensed with the Office of Chairman of "Hygeia".

A motion was made by Mrs. McDonnell that the President appoint a committee of

three, to consist of the following Chairmen: Archives, Historian, Press and Publicity, to sort over the papers of the Archives; these to be kept some place in Trenton. Motion carried.

After reading Chapter 1, Section 1, of the By-Laws, Mrs. Frederick Kich moved that the Nominating Committee be nominated from the floor. The following nominations were made:

Mrs. George A. Rogers, Chairman, Essex County.

Mrs. Dean H. LeFavor, Burlington.

Mrs. J. E. Roberts, Camden.

Mrs. Fletcher Gilpin, Union.

Mrs. James Hunter, Gloucester.

Moved by Mrs. Lippincott that nominations be closed. The Secretary was instructed to cast the ballot for the slate and the committee was declared elected.

Mrs. A. J. Casselman, together with the Treasurer, Mrs. Thomas P. McConaghy, were chosen members of the Budget Committee.

It was suggested that Mrs. Salasin instruct this committee to apportion the amount of money each County will pay to make up the deficit in the Fund for expenses for the National Convention in June.

Mrs. Teimer moved that a letter of appreciation be sent to Doctor and Mrs. Ily R. Beir for their splendid work in making the Convention a success, carried.

Mrs. Kinch suggested that a letter be sent to Mrs. Carl Surran, thanking her and her Committee for their untiring efforts in planning and arranging the entertainment for the Convention, so successfully.

No further business being presented, on motion of Mrs. Hubbard the meeting adjourned.

Respectfully submitted,

Mrs. Dan S. Renner.

The New York Academy of Medicine

THIS BOOK MUST NOT BE RETAINED FOR LONGER THAN ONE WEEK AFTER THE LAST DATE ON THE SLIP UNLESS PERMISSION FOR ITS RENEWAL BE OBTAINED FROM THE LIBRARY.

MAR 21 '38
JAN 2 1 '40
JAN 5 - 1961
MAY 2 8 1962
NOV 4 1964